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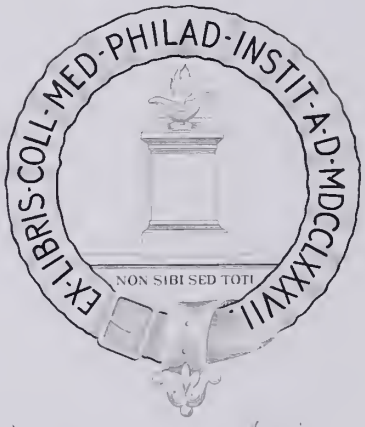

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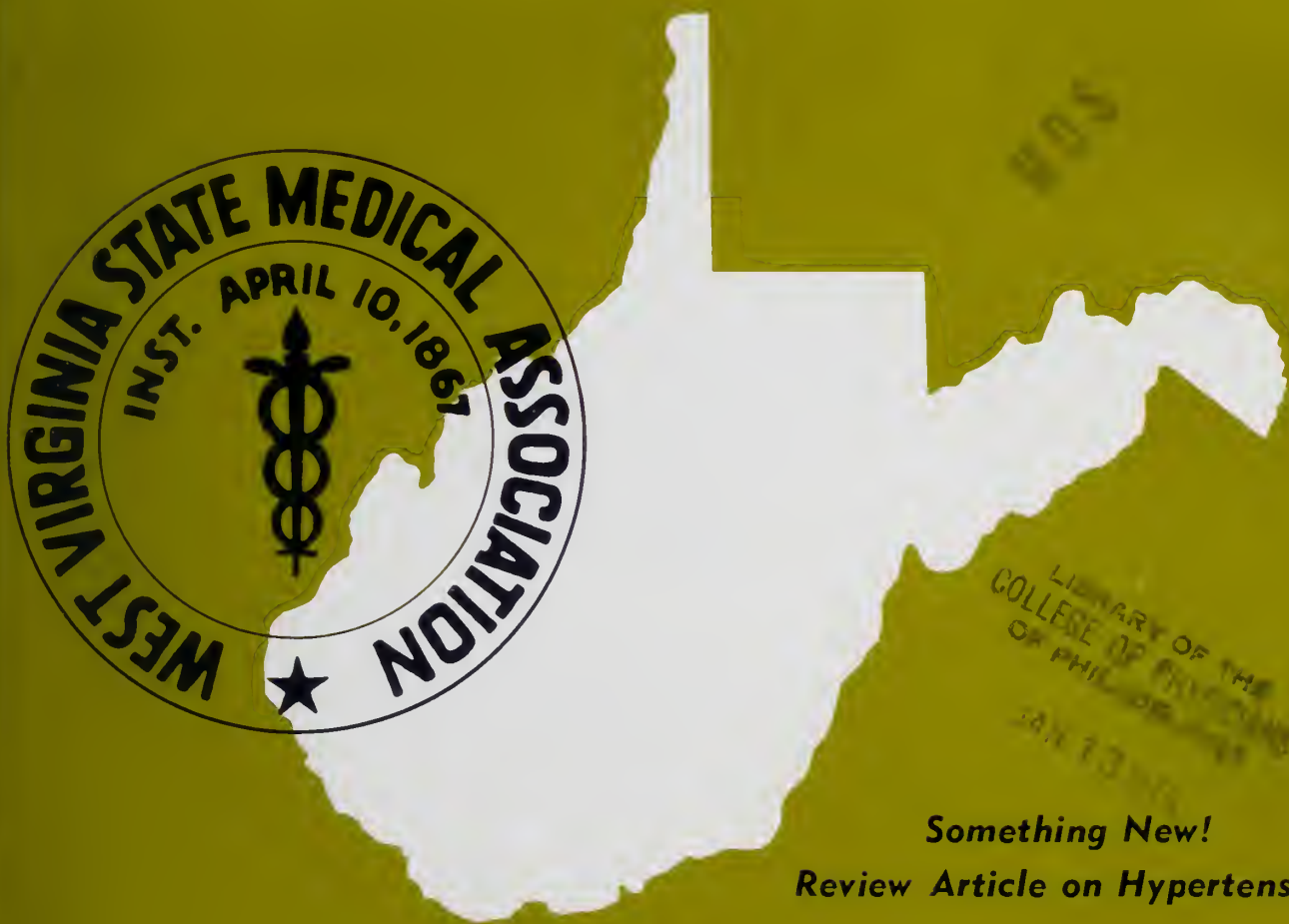

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11th Mid-Winter Clinical Conference
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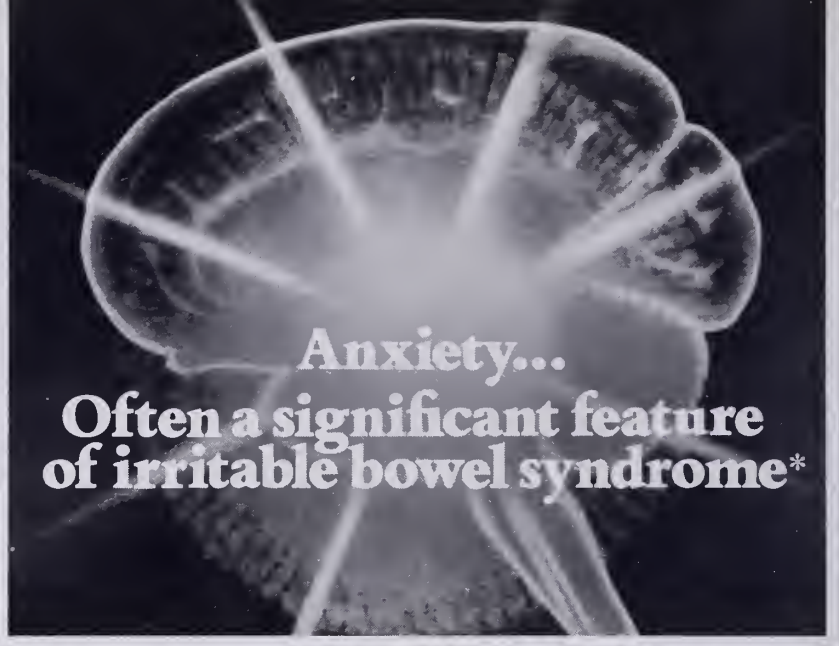
Volume 74 Number 1
January 1978



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The West Virginia Medical Journal

Vol. 74, No. 1 January, 1978

Review Article

Evaluation Of The Hypertensive Patient

Editor's Note:

Here is the first in a series of "review" articles which hopefully will appear several times a year in the *Medical Journal.* An editorial in the December, 1977, issue heralded this new educational challenge for our readers. At the end of the article you will find a true-false quiz of 10 questions—and elsewhere in *The Journal* are the answers to these questions. The Editorial Board solicits your reaction to this type of article. In particular, please do not hesitate to let us know if you take issue either with the material as presented, or the answers to the quiz.

RONALD R. SCOBBO, M. D.
Assistant Professor of Medicine, West Virginia University School of Medicine, Morgantown.

Patients can be accurately classified as to the type of hypertension and extent of end-organ damage, and then correctly treated, if the physician elicits an accurate history from the patient, does a careful physical examination, and makes judicious use of screening laboratory tests. This can generally be accomplished in an outpatient setting. Once the above is complete, the final steps are treatment, and patient education and compliance.

The physician's approach to the patient with high blood pressure has varied from one extreme to the other. In the not too distant past there was great emphasis placed on the "complete" work-up. Patients were always admitted to the hospital for lengthy stays and received every test imaginable. The yield was low, the hospital bill high, and treatment and follow-up often neglected. With recent greater emphasis rightly being placed on treatment, the pendulum sometimes has swung in the opposite direction—treat first and ask the diagnostic questions later, if at all. The truth, as usual, lies between the two extremes.

Patients can be accurately classified as to the type of hypertension and extent of end-organ damage, and then correctly treated, if the physician elicits an accurate history from the patient, does a careful physical exam, and makes judicious use of screening laboratory tests. In addition, almost all patients with high blood pressure can be evaluated in an out-patient setting. Obvious exceptions are hypertensive crisis and invasive diagnostic procedures.

A general outline of the types of hypertension, their characteristics, or lack thereof, will set the stage for how you approach the patient (Table 1). Note that the largest group (90 per cent) of this nation's 25 million hypertensives will fall into the category of essential hypertension.

The physician's objectives in assessing the hypertensive patient should include the following:[1]

1. The determination of the *severity* of hypertension and whether or not end-organ damage is present.
2. The identifications of other *risk factors* for coronary artery disease and/or stroke.
3. The identification of any other *coexisting disease* which would affect prognosis or change the therapeutic approach.
4. The search for any possible *curable cause* of hypertension which if corrected would obviate the need for lifelong medical therapy.

By far the most important segment of the evaluation is a careful and accurate history and physical examination. Certain clues in the history will help you categorize the type of hyper-

tension. For example: A positive family history of high blood pressure or a positive family history of premature death from heart attack or stroke is suggestive of essential hypertension. A history of urinary tract infection, proteinuria, or renal trauma is evidence in favor of renal hypertension. A history of palpitations, flushing, headache, or tremor is suggestive of pheochromocytoma or hyperthyroidism.

Certain drugs are known to induce high blood pressure, so a careful drug history is important, especially in women, since oral contraceptives can induce or aggravate hypertension. Many women do not consider oral contraceptives as drugs, so you must specifically inquire about them.

Questions concerning previous treatment or duration of hypertension are important. Rapid progression and abrupt onset of hypertension, especially in patients under 25 or over 60, would suggest renovascular hypertension. If a patient failed treatment on a previous antihypertension medication, the original diagnosis may have been incorrect or the patient may be in need of careful education or motivation.

Be complete in your examination of the hypertensive patient, but focus your attention on the following areas:

Measurement of blood pressure: Always measure the blood pressure in both arms while the patient is supine. A discrepancy of 10 mm Hg or more suggests an atherosclerotic plaque in the subclavian artery. After the patient has been standing for at least 60 seconds, measure the pressure again. A significant drop in pressure may confirm your suspicions of orthostatic hypotension. If the femoral pulses are diminished, measurement of reduced blood pressure in the thigh will indicate coarctation or other obstructive disease of the aorta or femoral arteries.

Optic Fundus: A reliable index of the severity of hypertension can be obtained from visualization of the retinal arterioles. Arteriolar narrowing, A-V nicking, hemorrhages and exudates, and papilledema form a visual guide of severity from mild to malignant (Table 2).

Examination of the heart: Search for an atrial gallop or fourth heart sound. This is among the earliest of physical signs and may be audible prior to detectable cardiac enlargement. A third heart sound will herald the onset of left ventricular failure, which carries with it a poor prognosis. The Framingham study concluded that in hypertension "congestive heart failure was a lethal phenomenon, with only 50 per cent surviving for five years."[2]

Peripheral Arteries: Since arteriosclerotic occlusive disease can be caused by hypertension, search for abdominal aneurysms, and listen for bruits over both carotid arteries, both supraclavicular spaces, over the abdominal aorta, over

TABLE 1

	Type	*History*	*Physical*	*Laboratory*
90%	Essential	Family history of hypertension Lability at first	End-organ damage depends on extent and duration of hypertension	Normal unless significant end-organ damage
10%	Renal			
	Arterial Parenchymal	Age under 25—over 65, abrupt onset, UTI, glomerulonephritis	Abdominal bruit	Selective renins Abnormal urine sediment
	Adrenal			
	Cushing's	Weight gain, bruising, weakness	Centripital obesity moon faces, striae	Dexamethasone suppression Low K+, abnormal cortisols
	Primary aldosteronism	Weakness	Occasional tetany, weakness	Low K+
	Pheochromocytoma	Tremor, flushing, hypermetabolic state	Same as history	VMA Metanephrines
	Coarctation		Diminished pulses in lower extremities, low blood pressure in legs	Chest x-ray
	Miscellaneous			
	Hyperparathyroidism	Stones, peptic ulcer	Normal	High CA++, PTH level
	Hyperthyroidism	Nervousness, weight loss, palpitations	Tremor, goiter, tachycardia, LID, LAG	High T4, High T3 RIA
	Oral Contraceptives	Estrogen	Normal	Normal

TABLE 2

Keith-Wagner (K-W) Eye Ground Changes
Grade I —Arteriolar Narrowing
Grade II —I + A-V Nicking
Grade III—I, II + Hemorrhages and/or Exudates
Grade IV—I, II, III + Papilledema

both renal arteries, and over both femoral arteries. A bruit over a renal artery is the most reliable sign of renovascular hypertension and is an indication for more extensive work-up such as a rapid-sequence IVP.

Abdominal Exam: In addition to listening over the abdominal aorta you can frequently palpate an abdominal aortic aneurysm. Palpation of both kidneys will provide important clues to polycystic renal disease, obstructive uropathy, or renal tumor.

General observations: The observant physician will diagnose Cushings Disease upon entering the examination room. Less obvious, but nonetheless important, clues to pheochromocytoma or hyperthyroidism are tremor, restlessness, perspiration, and tachycardia.

Laboratory and x-ray examination: A comprehensive and expensive battery of tests is *not* indicated in the evaluation of hypertensive patients. The desirable tests which give maximum information and conform in general to the "Guidelines for Hypertension Control"[3] proposed by the Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure, are listed in Table 3.

The CBC and ESR will give you an indication of the general health of the patient. The urinalysis, serum creatinine, and BUN assess renal function since the kidney may be either an end-organ of hypertensive damage or a cause of high blood pressure. Assessment of other stroke or coronary risk factors is provided by serum cholesterol and fasting serum glucose. A chest x-ray and an EKG provide valuable information on cardiac size, and arrhythmias or conduction disturbances. Finally, a normal serum K+ makes the diagnosis of primary aldosteronism very unlikely. Note the lack of a "routine" hypertensive IVP in every patient. Note also that peripheral renin assay is not included in the above.

TABLE 3

Laboratory and Ancillary Examinations For Evaluation of Hypertension

CBC, ESR	Serum cholesterol
Urinalysis	Serum creatinine/BUN
Serum K+	Chest x-ray
Fasting glucose	EKG

While it is possible to subdivide patients with essential hypertension on the basis of high, low, or intermediate renin levels, it is not at this time practical to do so for two reasons: first, an accurate, cheap renin assay is not universally available and, second, unless the renin levels are normalized by an index of salt balance via a 24° urine collection for sodium, the actual numbers may have little or no meaning.

Nonetheless, if the physician does want an idea of his patient's renin status, it may not be necessary to measure peripheral renin or do a 24° urine for sodium. Instead, if the patient responds well to a diuretic alone, the physician can infer that his patient is of the low-renin type. If response to a diuretic is poor, then the addition of propranolol, because of its anti-renin properties, will categorize the patient for him. If response to propranolol is excellent the patient is probably a high-renin type.[4]

By following the above approach, the physician's objectives in evaluating the hypertensive will have been met at reasonable cost to the patient. The physician will have obtained a good idea of the severity of his patient's hypertension, the presence or absence of other cardiovascular risk factors, whether any other co-existing disease would modify the prognosis, and he will have ruled in or out a secondary form of hypertension.

Once this is complete, the next steps are treatment and patient education and compliance.

The author wishes to thank Barbara Soukup for her help in the preparation of this manuscript.

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And Now For A Quiz On The Material Presented Above!

(Answers on Page xix)

TRUE OR FALSE

1. Most hypertensive patients have a secondary form of hypertension.

2. Most hypertensive patients should be hospitalized for proper evaluation of their disease.

3. A reliable index of the severity and duration of hypertension can be obtained from examination of the optic fundi.

4. Congestive heart failure occurring in a hypertensive patient is a relatively benign condition.

5. A comprehensive battery of lab and x-ray tests should be performed on all hypertensive patients.

6. A bruit heard over a renal artery is the most reliable sign of renovascular hypertension.

7. Palpation of the femoral arteries is an important part of the physical examination in hypertensives.

8. A third heart sound (S_3) heard in a hypertensive patient has no meaning.

9. Oral contraceptives may induce or aggravate hypertension.

10. The kidney may be either a cause of hypertension or an end-organ of hypertensive damage.

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Report: 40 Cases Of Closed Intramedullary Nailing Of The Femur

JOHN T. SAMSELL, M. D.
Resident, Division of Orthopedic Surgery, West Virginia University Medical Center, Morgantown.

Closed intramedullary nailing of the femur was begun at West Virginia University Hospital in 1972. We felt it would prove to be a plausible means of shortening hospitalization, hastening ambulation, decreasing morbidity and reducing the economic burden to the patients. We have used the closed technique on 41 femoral shaft fractures. The complications and advantages encountered with this method are reviewed.

FORTY patients with 41 acute mid-shaft femoral fractures, ranging in age from 16 to 56, underwent closed intramedullary nailing using a Kuntscher clover leaf rod. All fractures were closed, although two had small puncture wounds at the skin surface. Two patients were pregnant; however, they progressed to normal uncomplicated deliveries.

Method

On initial presentation to the emergency ward, patients were placed in either a Kuntscher distraction bow or balanced suspension traction. A Steinman pin was placed in the distal femur or proximal tibia, depending on the preference of the admitting resident. Enough force was applied to the fractured extremity to gain at least one-cm. distraction at the fracture site. This simplified the closed nailing at a later date.

The average time from fracture to surgery was 10 days, the shortest being five, and the longest 20. A five-day minimum was allotted to all patients to allow time for initial shock to subside and the patient's condition to stabilize. The incidence of fat embolism is statistically greatest during this period and is a contraindication to intramedullary nailing, according to Bohler.[1] Prophylactic antibiotics were not routinely used in this series of patients.

General endotracheal anesthesia was used in all patients, except in the two pregnant females for whom continuous epidural and spinal anesthesia proved adequate.

Surgical Technique

The technique described by Kuntscher was utilized with some variation at the discretion of the attending surgeon.[2,3,4,5] The procedure is carried out with the patient placed in the lateral

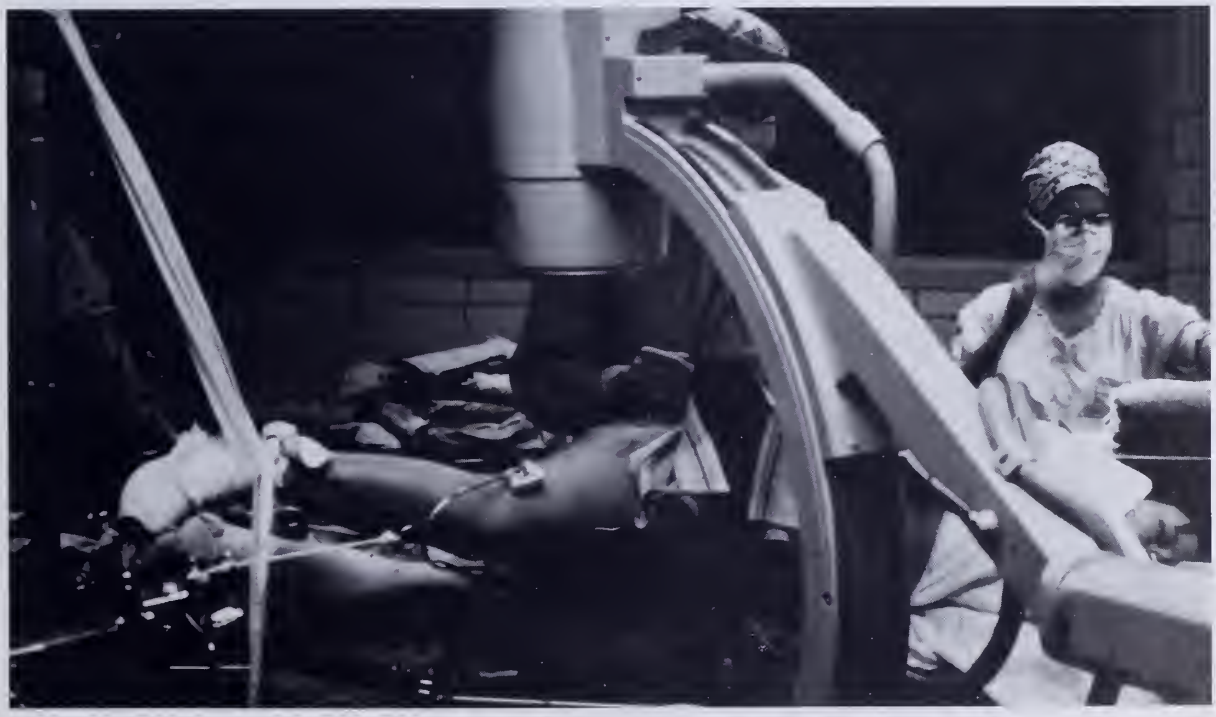

Figure 1. Prior to draping, the patient is positioned on the fracture table and the reduction practiced.

position on the fracture table. Kuntscher advises determining proper nail size by taking an x-ray one meter from the fractured limb and then calculating the size of the medullary cavity in width and length with an Ossimeter.[4] We found this to be an unnecessary step. With transverse mid-shaft fractures, reaming can be started with the smallest reamer and enlarged progressively until there is cortical bite on both sides of the fracture site. The largest reamer is equivalent to the width of the nail. The nail length is measured from the guide pin, which is inserted to the superior pole of the patella with the aid of the image intensifier.

Adequate fracture reduction is critical to the success of this procedure. This should be accomplished prior to the operation and verified with an image intensifier. Kuntscher uses a crutch and sling to manipulate proximal and distal fragments into position.[4] Bohler prefers the Wittmoser apparatus, which utilizes two rings placed over the extremity to exert manual pull and counter-pull to correct displacement.[1] We used the crutch and sling method and found it helpful.

After trial reduction, the skin over the greater trochanter is prepared and draped in a sterile manner. A small incision is made just proximal to the greater trochanter and carried through the subcutaneous and deep fascia. The muscle layer is then bluntly divided to expose the tip of the greater trochanter. A triangular awl is inserted into the medullary canal at the tip of the trochanter with care to direct it toward the knee and the center of the medullary canal of the femur. The enlarging awl is passed into the defect created by the triangular awl. A blunt guide pin is passed into the medullary canal through the enlarging awl. The fracture is reduced and the guide pin advanced across the fracture site into the distal fragment. The advancement of the pin should be followed closely with the image intensifier in two planes.

The enlarging awl is removed and the smallest reamer is passed over the guide pin into the medullary canal and advanced slowly. The reamer is advanced cautiously across the fracture site to avoid damage to the distal fragment. The assistant will need to manipulate the fracture to make this step more exact. The reamer is advanced to the tip of the guide pin and the next larger reamer is then passed in the same manner and this is repeated until a strong cortical bite is felt on both sides of the fracture site. The rod to be inserted is equivalent in diameter to the largest reamer. Rod length is determined by measuring the guide pin from the base of the trochanter to the superior pole of the patella. The proper rod is inserted over the guide pin and advanced

Figure 2. Crutch and sling method of reduction. Small guide wire or small Kuntscher rod can be inserted in the proximal fragment to aid reduction.

cautiously with the slotted mallet. Progress of the rod should be followed across the fracture site with the image intensifier. Once the rod is well within the distal fragment, the traction is released; and if a Steinman pin remains in the distal femur, it is removed by the assistant. The guide pin is removed and the rod advanced until it is even with the greater trochanter. The wound is closed and ace wraps applied from the toes to the groin. Postoperative reduction films should be taken in the recovery room.

During the postoperative period, patients are encouraged to straight leg raise against gravity. Once adequate quadriceps function is attained, crutch ambulation with weight bearing, as tolerated, is encouraged.

Operative Complications

Failure of fracture reduction: In 41 femurs, we were unable to gain reduction in one case and the closed nailing was abandoned in favor of conservative treatment in balanced suspension traction for six weeks followed by a 1½ hip spica cast. This case occurred when our technique was not well perfected. Polaroid films were used prior to the acquisition of the image intensifier. We do not recommend intramedullary nailing unless an image intensifier is available.

Eccentric reaming: Rascher *et al* emphasize that poor guide pin replacement can lead to eccentric reaming and possible splitting of the cortex or impoundment of the nail on the distal fragment.[5]

Complications were encountered in three patients where the anterior cortex of the proximal fragment was split, leaving an anterior bone spike. One patient, as the fracture healed, developed quadriceps entrapment and limited range of knee flexion. Nine months after the closed intramedullary nailing, the Kuntscher rod was removed and the anterior bone spike excised. Three months later, the patient had regained 90° of knee flexion and the fracture was healed.

The other two patients were found to have unstable fixation postoperatively. Both were placed in a single spica cast and ambulation was accomplished with non-weight-bearing crutches. The fractures healed uneventfully.

Hypotension: Kuntscher lists hypotension as one of the complications of closed intramedullary nailing. He states: "When driving a nail, the pulse rate in particular has to be checked! When the rate increases and the pulse becomes soft, interrupt nailing immediately and wait until it returns to normal."[4] One of our patients developed a temporary hypotension during the procedure and, by adhering to Kuntscher's principle, the nailing was completed without further complications.

Breakage of the reamer head: In reaming the medullary canal it is possible for the head of the reamer to break off within the medullary canal. This complication occurred once in our series, but by using the blunt guide pin, the reamer head was withdrawn.

Postoperative Complications

Excess rod protrusion: Twelve patients were found to have the rod protruding one to two inches above the greater trochanter as measured on the postoperative x-ray films. Seven of these had associated hip pain after ambulation was begun. This was a temporary complaint and resolved with time. However, it emphasized the

Figure 3. This is an example of eccentric reaming, anterior bone spike and unstable reduction placed in simple hip spica cast.

fact that the rod should only be advanced to approximately one cm. above the tip of the greater trochanter.

Antalgic gait: Three full-weight-bearing patients walked with a slight antalgic gait. When quizzed about the reason for this, no specific symptoms were elicited. This was a temporary finding and with due course disappeared.

Knee effusion: Hansen points out that postoperative knee effusion is noted in approximately 100 per cent of the cases.[3] We also found this to be the case. The effusion is temporary and disappears as the knee is mobilized.

Shortening: Shortening and rotational deformity were not found to be major problems. The patient earlier described with quadriceps entrapment suffered a one-inch shortening that required a shoe lift.

Bone cap: Heterotropic bone formation over the proximal portion of the rod was a frequent finding at follow-up examination; however, this was not associated with hip pain or limited range of motion. Occasionally, the new bone caused some difficulty in locating the proximal portion of the rod at the time of extraction. Fifteen patients demonstrated bone caps but there was no association with the amount of rod protrusion.

Figure 4. Excess rod protrusion.

Infection: Kuntscher points out that with closed nailing the danger of infection is minimal because of the small incision and minimal disruption of tissue.[4] Clawson reported no infections in 46 closed intramedullary nailings.[2] Rascher reported two superficial and one deep infection in 42 closed intramedullary nailings.[5]

There were three infections in our series, none of which required replacement of the rod with one of a larger size. Infection did not occur in association with the compound fractures.

One patient developed drainage at the operative site during the early postoperative period, but the infection cleared with local wound care. The rod was removed electively 17 months later and the fracture was healed.

A pin tract infection developed in another patient and was followed a short time thereafter by drainage at the site of the incision. The rod was extracted one year after the fracture healed. There has been no further evidence of drainage.

We experienced one late infection in a female who was subsequently found to have a mild adult diabetes mellitus. Her postoperative progress was slow and she experienced persistent pain over the proximal portion of the rod with limited range of motion in her knee. Six months after the operation, drainage erupted at the incision site. Her cultures demonstrated E. coli and she was administered a course of parenteral antibiotics. The drainage subsided considerably as did her pain and, one month later, she was partial-weight-bearing with a walker.

Subjective Complaints

Eight patients were aware of pain over the proximal end of the rod. This was usually an early symptom and subsided in time. Five patients complained of knee pain and three of pain at the fracture site. The three patients who complained of persistent pain subsequently developed an infection.

Summary

Forty patients with 41 fresh, mid-shaft, femoral fractures treated by closed intramedullary

nailing were reviewed. The complications encountered with this technique include:

1.	Failure of fracture reduction	2.4%
2.	Eccentric reaming	7.3%
3.	Hypotension	2.4%
4.	Reamer breakage	2.4%
5.	Hip pain	21.9%
6.	Knee effusion	100%
7.	Heterotropic bone formation	36%
8.	Protruding rod	29%
9.	Infection	
	Superficial	2.4%
	Deep	4.9%

Nonunion, malunion, and nail breakage have not been complications in this series.

It is important to note that closed intramedullary nailing of the femur is a complicated procedure. We do not recommend the use of this method unless the proper equipment and personnel are available.

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Impact Of New Chemicals On Skin

All sorts of things in the environment can cause skin problems. Medical science has learned much about how to predict possible adverse reactions to chemicals and other substances in advance, but there is still more to be learned.

These are the conclusions of Victor A. Drill, M. D., pharmacologist of the University of Illinois School of Medicine, Chicago, in the introduction to the American Medical Association's new book on the effects of new chemicals on the human skin.

Doctor Drill summarized research progress in the past 30 years in gaining understanding of the processes affecting the skin, and pointed out that much research is still going on.

Entitled *Cutaneous Toxicity,* the book contains papers presented at a recent symposium sponsored by the Society of Toxicology in cooperation with the AMA. It is published by Academic Press, Inc., 111 Fifth Ave., New York, N. Y. 10003. Copies are available at $14.50 from the publisher.

Proper Interpretation Of Chloride Determinations In The Early Diagnosis Of Bromism – A Reminder

GERALD E. VANSTON, M. D.
HOSSEIN SAKHAI, M. D.
Pathology Service and Neurosurgical Service, St. Mary's Hospital, Huntington, West Virginia.

Elevated chloride levels by automated laboratory methods are an important factor in recognizing bromism. If additional chloride levels by manual potentiometric laboratory methods are reported as normal, this should only accelerate the search for bromide toxicity. There is a distinct difference in the manner in which bromide affects the results of various methods for chloride determination.

BROMISM is a relatively uncommon toxic state which usually presents as a neuropsychiatric derangement with varying complaints, but generally the symptoms presented are headache, personality changes, dizziness, poor concentration and abnormal gaits. Patients are usually taking non-prescribed, bromide-containing counter preparations in excessive amounts. Any combination of these symptoms can prompt even the most astute investigator to search for a diagnosis with procedures which might otherwise have been avoided.

Almost all hospitals, physicians' offices, and clinics screen obviously ill patients with a panel of automated chemistry tests. The SMA 12/60 and SMA 6/60 (Technicon Corporation) are the instruments most commonly used. In acute bromide toxicity, the SMA laboratory chemistry report usually displays a markedly elevated chloride. This has been reported many times as an important clue in the diagnosis of bromism.[1]

Many physicians and laboratory personnel repeat or check high-SMA screened values with manual or bench chemistry methods, especially on patients whose diagnoses are not yet secure. In bromism, manual potentiometric methods for chloride determination will yield normal results.[1] If the investigating physician or laboratory technician recognizes this paradox, a diagnosis of bromism should be strongly suspected and serum bromide levels should be quickly determined.

Case History

A 42-year-old male Caucasian was referred to St. Mary's Hospital with mental confusion and difficulty in walking of five days' duration. He had complained of headache in the past and had been taking large amounts of non-prescription medication (Nervine) containing bromides. On admission, except for abnormal gait, the neurological examination was essentially negative.

Admission laboratory workup revealed an elevation of serum chloride by SMA 12/60 methods (124 mEq/L). A lumbar puncture with studies of the cerebrospinal fluid revealed normal pressure, no cells, and protein of 51 mg/100ml. An x-ray film of the skull, brain scan and bilateral carotid arteriograms were negative. An electroencephalogram was abnormally slow. Repeat electrolytes by a manual potentiometric method showed chloride of 103 mEq/L. Because of this difference of chloride by two different methods, and history of taking Nervine, a serum bromide level was checked and found to be 336 mg/100ml. His condition rapidly deteriorated while being studied. He demonstrated acute psychotic behavior and became restless and combative. He became unable to walk and talk and stopped taking fluids by mouth. His serum bromide level rose to 356 mEq/L on the third admission day despite no administered medication.

He was treated with large amounts of intravenous fluids including normal saline. Large amounts of Thorazine were also used. His condition gradually improved.

He was discharged 20 days after admission with the serum bromide level down to 120 mg/100ml and serum chloride level was 108 mEq/L by SMA 12/60 and 99 mEq/L by manual methods. He was seen four weeks later and found to be well and had already resumed his occupation.

Discussion

The SMA 18-60 determines chloride by the $Hg(SCN)_2$ - $Fe(NO_3)_3$ with general equations as follows:

$$Hg(SCN)_2 + 2\,CL \longleftrightarrow Hg\,CL + SCN$$
$$3\,SCN + Fe(NO_3) \longleftrightarrow Fe(SCN)\,3 + NO_3$$

The reaction depends on the displacement of SCN from Hg^+ by chloride ion. Bromide has greater affinity for Hg^+ and equal molar quantities of bromide yield more $Fe(SCN)_3$ than chloride does, thus, spuriously elevating the chloride level.[3]

In our laboratory, manual chloride methods are determined by chloride meter (Corning #920 M). This chloride titrator actually measures total halide. This method depends on the passage of constant direct current between silver electrodes producing Ag^+. Ag^+ reacts with halide, forming silver halide. After all halide combines with Ag^+, free Ag^+ *accumulates*, causing an increase in current across the electrodes that activates an indicator circuit.[2] Since Br^- displaces Cl^- ion in the extracellular fluid, total halide serum concentration is usually within normal ranges in bromide toxicity.

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Blacks, Orientals Seek Nose Changes

The "nose job" is becoming more popular among Americans of black or Oriental heritage, according to a recent report in the Archives of Otolaryngology, a journal of the American Medical Association.

"In this era of ethnic and racial pride, it is somewhat surprising that a large percentage of non-Caucasians undergoes rhinoplastic surgery," commented Sheldon S. Kabaker, M. D., of the University of California Medical School at San Francisco.

Sometimes the objective is to gain a more normal ethnic appearance, but the majority of the patients seek a more Caucasian appearance, Doctor Kabaker said.

"The performing arts and the advertising media still emphasize Caucasian standards of beauty, even when catering to black and Oriental consumers. Glamor magazines in the Orient feature Caucasian models in some of their advertisements." These influences lead these people to seek nose surgery, he observed.

Achieving a thin, finely sculptured nasal appearance in a non-Caucasion usually is not possible, and even if it were it would not be in harmony with the rest of the facial features. Persons with a wide and flat nose "will be content with a less than perfect result and these persons accept the visible scarring that may occur with rhinoplastic surgery."

Munchausen's Syndrome: A Case Report

GINA PUZZUOLI, M. D.
Resident in Psychiatry, Department of Behavioral Medicine and Psychiatry, Charleston Division, West Virginia University Medical Center.

This is a case report dealing with Munchausen's Syndrome in which the patient feigned cardiologic problems resulting in admission to the CCU. His story became somewhat contradictory, and the admission diagnosis of ischemic heart disease was questioned. Subsequent investigation and confrontation of the patient revealed the true diagnosis. The patient then agreed to undergo psychiatric treatment, but later signed out against medical advice. A short discussion of Munchausen's Syndrome follows the case report.

MR. M, a 46-year-old black male, came to the emergency room with the chief complaints of substernal chest pain radiating to his left arm, tachycardia, cold sweats, and a fast respiratory rate. He further stated that he had undergone coronary artery bypass graft in 1974, had a pulmonary embolus in 1975, and had been on heparin ever since. He stated he was a nuclear physicist working in Paris, France, and was in Charleston to meet with the State Legislature regarding a power plant. He was staying at a local hotel. Physical examination revealed a scar compatible with a coronary artery bypass procedure, numerous abdominal scars, tachycardia, and tachypnea. The EKG showed ischemic changes of undetermined age. CPK, CPK isoenzymes, LDH, LDH isoenzymes, and routine laboratory work were drawn. The patient was admitted to the CCU.

Although at first the patient was very courteous and cooperative, a few hours after admission he became somewhat demanding of attention and pain medication. After several hours of this behavior, the nurses called the resident to see the patient. The resident saw two conflicting pictures: (1) the one the patient presented and (2) the one the nurses presented. The resident became concerned and eventually consulted a cardiologist. The cardiologist became suspicious and asked the nurses to keep an eye on the patient and carefully chart his requests and behavior. In the meantime the staff contacted several hospitals and the authorities. None of the hospitals recognized the patient or his description. A set of the patient's fingerprints sent to the police also failed to reveal anything. Members of the Legislature were contacted and denied any knowledge of the patient who claimed to be working with them.

By this time the patient's enzymes and isoenzymes showed there was no evidence of recent myocardial damage, and serial EKG's showed the damage not to be recent. At this point the cardiologist and medicine resident decided to confront the patient. They quietly explained to him that they wanted to help him, but they had reason to believe that he had not been telling them the entire truth. They then presented him with the results of the lab tests and the fact that they were unable to document his story of why he was in Charleston. They also told him that his Demerol requirement had been rather high.

By this time the patient realized the doctors had no intention of pressing legal actions against him and told the following story. He was born in Haiti of an African mother and Scottish father. In Haiti, his family was of the upper class and enjoyed respect and prestige. When he was 15, his family moved to South Carolina. There he was the brunt of prejudice and mockery, not only from his peers but also from his teachers. He said be became bitter. His father was completely out of touch with what was going on with Mr. M as he was very busy with his business affairs. Mr. M's mother was aware of what was going on, but did not feel it was her place to speak out. Finally, Mr. M. became so angry that he spoke out against his teachers. His parents then sent him to school in California where he did well. After graduation he joined the Army to "try and fit in again."

While in the service he was sent to Korea, was shot, and suffered injury to his kidney. His left kidney was surgically removed. He was given a great deal of Demerol and was shuffled from one Army hospital to another. From 1952 to 1958, he was constantly in and out of Army hospitals. He is, again, quite bitter about this treatment. By now he was quite disillusioned with this country, its doctors, and its laws. Also, by this time he was addicted to Demerol. He said he looked for a group of people as angry

as he was and during the early 1960's he became involved with the Black Panthers and later spent several years in jail for his involvement.

In 1975, he had his coronary artery bypass surgery. After leaving the hospital, he tried to find a job but was unable to, and at one point went to an employment agency. The lady told him that she could not help him and that he would have "to learn to live by his wits." Mr. M. said, "I took her literally, and at that time began to go from hospital to hospital with my stories. It became a battle I learned to enjoy."

Very little of the above story has been substantiated except for his history of CABG and numerous admissions to VA hospitals. A psychiatric consult was obtained and the patient repeated the above history. He was transferred to the Behavioral Medicine Unit and begun on a withdrawal schedule of Demerol. While a patient on the psychiatric unit both staff and patients complained of feeling manipulated by Mr. M. He did comply with the rules of the ward. After approximately two weeks, he disappeared from the ward. A local church called the unit a few hours later and said he was there asking for help and pain medicine. The psychiatry resident spoke with Mr. M. and asked him to return. Mr. M refused and when he failed to return in six hours, he was discharged against medical advice.

Discussion

Richard Asher described the first published report of Munchausen Syndrome and coined the the name. He derived the term from Baron Heironymous Karl Fredrich Munchausen of Hanover, Germany. The Baron was in the Russian calvary from 1737 to 1739; and, upon his retirement, he returned home to his estate. He often told somewhat exaggerated accounts of his wartime adventures to entertain his friends and family.[1] Mr. M was given the diagnosis of Munchausen's Syndrome as he meets the following criteria described by Ashner:[2]

(1) The patient traveled widely.

(2) The patient bore multiple scars.

(3) The patient told a dramatic history of his illness.

(4) There is evidence of multiple hospital admissions.

(5) The patient eventually quarrelled with the staff and left the hospital against medical advice.

In 1968, Spiro reviewed the medical and psychiatric literature and found 37 cases which initially presented as: 9 cases—abdominal pain and/or vomiting, 8 cases—bleeding, 10 cases—neurologic problems, 5 cases—fever, and 5 cases—cardiovascular problems.[3]

As with most of these patients, Mr. M consciously simulated an illness. Undoubtedly, his pathology was more complex than a malingerer. He seemed to receive secondary gain merely from being in the hospital, deceiving the medical staff. No doubt some hysterical mechanisms enter into the pathology, but by definition hysterical symptoms are not consciously produced.[4] In Mr. M's case it seemed as though deprivation of affection in childhood, disturbed relations with authority figures, free-floating anger towards "the system", and poor interpersonal relations all provide the background for his need to receive constant attention in a hospital setting and to take pleasure in "beating them at their own game".

Obviously, Mr. M had an uncanny ability to outwit experienced physicians and even involve them in an un-therapeutic situation. As with most of these patients, by the time his diagnosis was made, he had undergone numerous hospitalizations and surgeries. The iatrogenic damage is unquestionable, but certainly difficult to avoid. He again fit the general description of a Munchausen's in that he seemed poorly motivated to follow through with psychiatric intervention. Various administrative means of blacklisting him from hospitals will help other institutions from being deceived, but will do little to help him as a patient. It is quite easy, as a physician, to resent such a fraudulent patient. However, in a psychiatric sense, his difficulties are quite real. Ideally, long-term psychotherapy probably offers the only real chance of improvement. The most difficult obstacle to this treatment is lack of patient compliance, as Mr. M so well demonstrates.

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The President's Page

WHAT ARE YOU DOING?

Guest Author
Jo Skirtish (Mrs. Joseph T.) Mallamo, President
Auxiliary to the
West Virginia State Medical Association

Dear Doctor,

In the December issue of *The Journal*, Dr. John H. Budd, President of the American Medical Association, asked you to look in your mirror. If and when you looked, was there an Auxilian standing beside you? If not, why wasn't he or she there?

I've heard many conversations about the attacks on medicine. You'd be amazed to know that the people who talk the most about "poor medicine" have thus far done the least as far as defending your beautiful profession. Let me say this—if and when medicine is sold down the river, I'll lay you odds that the guy or gal who has done the least will be the very person who will scream the loudest!

After you've thought about this, take this message home—especially if your spouse is not an Auxilian. Ask that wife or husband these questions: "What do you know about PSRO, HMO, and all those other 'nice' things that have been dropped on medicine in recent years?" "How about health legislation in our state—in our nation?"

After your spouse has thought about these things, then my question is this:

What are *you* doing?

Jo Skirtish Mallamo (Mrs. Joe, T.)

The West Virginia Medical Journal

Editorials

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author shall be held entirely responsible.

LET THE GOVERNMENT DO IT

I happened upon a Buffalo, New York, newspaper dated 1934 and was much surprised by the headlines. It could have been yesterday's or today's paper. These headlines read:

Drought Conditions Worsen In Midwest; Unemployment Figures Up Again; Sewage Disposal Contaminating Lake Erie; Steel Mill Wastes A Problem On Niagara Frontier; Coal Miners On Wildcat Strikes; Welfare Funds Inadequate.

Over 43 years have passed and these problems have not been "solved" by government bureaucracy, which has spent billions, created thousands of jobs in many areas and raised the pay of the bureaucratic worker to about the highest in the nation in their respective fields.

Then come the back pages and one gains real insight into accomplishments without all this bureaucracy. These headlines read:

Poliomyelitis Admissions Increase to 436 This Past Week; Tuberculosis, New Cases 216; Pneumonia Deaths Hit Seasonal Peak.

Obituary pages read contained deaths at ages 3, 8, 35, 42, 47, 54, 76, plus infants.

During this same period of time, mostly due to dedicated efforts of non-regulated medicine, the accomplishments are evident: Polio almost non-existent, tuberculosis tremendously decreased, with sanataria almost all closed, pneumonia no longer the "old man's friend" or "great killer," and obituary pages reading ages 76, 79, 88 and 92.

Physicians have been the one group historically trying to eliminate their own jobs by improving health care. Maybe we should join the bureaucracy to create many more jobs (this has happened in the past two decades in governmental medicine). Our salary increases then could be increased in proportion to many other increases. The 1967-1976 Consumer Price Index shows physicians' increase as 184.7 (based on 100 in 1967). Other increases were: lawyers, 199.9; postal services, 222; painting, 225.6; baby sitters, 214; coffee, 243; chocolate, 233.5; water and sewer, 188.7; haircuts, 186.6; bathroom tissue, 234.4; Social Security taxes, 308 (1977, 332.4), and state and local taxes in areas in excess of 300. When examined in this light, how maligned we are by those headlines showing physician fees excessive.

When the accomplishments are measured and the income truly analyzed, do we really want the government to run medicine? Do we want unchanging headlines of deaths from disease? Do we want costs without performance? For my part, I would rather see dedicated physicians performing as they have in the past.

We do need to weed out a few bad apples, but why throw away the car because it needs greasing?

HEALTH CARE COSTS

Government seems to maintain that in professional standard review organizations it has given physicians almost exclusive control over decisions on utilization, quality, and, by implication, costs of services. Actually, government has given nothing. Physicians have always had exclusive control over decisions on utilization and on quality of medical care. The only gift government attempts to give is blame for high costs of medical care. Physicians decline, as graciously as possible, to accept this latter dubious gift.

Inflationary fiscal policies by government as well as insatiable demand for services created by campaign rhetoric must share some measure of blame for increased medical care costs along with technological innovations of a highly complex nature which save lives and mitigate suffering, but at an exponentially greater cost factor. Rather than apologizing for costs of these inno-

vations, the medical profession takes some pride in the new healing capability it possesses as a result of these.

Physicians, as a group, have as great a concern for costs as any others, but because of the unique contract with which a physician binds himself to each patient, concerns about costs can never be primary. A physician's obligation is to his patient, not to whatever fund is paying for that patient's care. Employers, unions, government or insurance companies make, from time to time, certain promises to their constituents, assuring them that in case of illness or injury certain specific medical care benefits are theirs. When physicians act as the vehicle for carrying out this transaction between the patient and that body which made the promises of care, the medical profession is lashed with abuse for promoting high medical care costs. We are scolded for representing the patient's interest so well. One could more logically blame high food costs on the grocer for selling so much food to his customers because statistics show Americans eat too much and are too fat.

The average consumer is concerned about health care costs, but probably not at the time he or one of his loved ones is desperately ill. He is mostly concerned with costs when the bill comes, just as he is concerned with runaway costs of government every April 15. The remainder of the year he is fairly content in having an orderly and prosperous environment, furrowing his brow occasionally at strange and intrusive new proposals from the halls of Congress relating to government's concern for his welfare.

The medical profession fulfills obligations to its constituents as well as it possibly can. If government, labor unions, employers and insurance companies did as well, it is unlikely health care costs would be an issue.

'FOR GENERAL SALUBRITY UNSURPASSED'

This month, our *Journal* has a new face. It again carries the seal of the West Virginia State Medical Association as well as a map giving the outline of our state. The boundaries of our state are no less sinuous and circuitous than described in an editorial in the New York Daily Tribune of Saturday, December 13, 1862. We who have lived here are pleased with it, and it is pleasing to have the outline of our state depicted on the cover of *The Journal.*

The following is abstracted from an editorial of the New York Daily Tribune as above mentioned:

"West Virginia"

This new State (so far as Congress can make it so) comprises forty-eight counties of old Virginia lying west of the Allegany Mountains. Its boundary is a miracle of crookedness, the tortuous channel of the Ohio being rivaled on the other side by an exaggerated Virginia fence of a line zigzagging over the hundred and one ridges of mountains that cluster in the center of the old State. It is hardly possible to convey an idea of the boundaries without a map, and we have therefore had one made and print it herewith. . . .

It is scarcely necessary to mention the geographical features of West Virginia. It is a land of rough hills and fertile valleys, of innumerable streams, pure and bracing air, and for general salubrity is unsurpassed. . . . In mineral wealth the new State is particularly fortunate. The Salt Springs of the Kanawha Valley, and the vast beds of coal in other sections are the most important. There are also immense beds of gypsum, with ores of iron, lead, copper, etc. Cannel and bituminous coal of the best quality are among the most valuable deposits of the Kanawha and Ohio Valleys. . . .

Cut off from the seaboard by almost impassable mountains, and repelling settlers by the stigma, rather than the fact, of Slavery, this highly favored region for farmers has been shunned by the wave of Western-bound agriculturists, and her development has rested altogether with her own hardy, but ill-instructed people. Under her new Constitution, the black shadow of desolation will soon pass away, and the strong arm of free labor will soon give the new State an impetus like that which but a few years ago started Wisconsin, Iowa and Minnesota into such lusty and promising life.

Although our state has not been free of bionomical problems since that editorial of more than a century ago, we in West Virginia can still agree "and for general salubrity is unsurpassed."

GENERAL NEWS

Plans Completed For Mid-Winter Clinical Conference Program

Plans were completed in December for the Eleventh Mid-Winter Clinical Conference to be held Friday afternoon through Sunday morning, January 27-29, in Charleston at the Holiday Inn Charleston House.

The 1978 continuing education event is sponsored by the West Virginia State Medical Association, West Virginia University School of Medicine, and Marshall University School of Medicine.

William F. Jessee, M. D.

Arthur E. Kelley, M. D.

The conference is approved for 12 credit hours in Category 1 of the American Medical Association Physician's Recognition Award—and also is acceptable for 12 prescribed hours by the American Academy of Family Physicians.

Friday Afternoon

The conference will begin at 2 P.M. on Friday, January 27, with opening remarks by Dr. Joseph A. Smith of Dunbar, President of the State Medical Association.

Presiding at the opening session, "Birth Control and Estrogen Update," will be Dr. Charles A. White of Morgantown, Professor and Chairman, Department of Obstetrics and Gynecology, WVU School of Medicine.

The speakers and their topics will be "Present Status of Oral Contraceptives"—E. Noel McIntosh, M. D., Sc. D., Morgantown, Associate Professor, Departments of Medicine and Obstetrics and Gynecology, WVU; "Mechanical and Other Non-Hormonal Techniques for Birth Control"—Narinder N. Sehgal, M. D., Director, Department of Obstetrics and Gynecology, Charleston Division, WVU; and "Estrogens for the Menopause—Yes or No?"—David J. S. Hunter, M. D., Morgantown, Associate Professor, Department of Obstetrics and Gynecology, and Director, Fetal-Maternal Medicine, WVU.

Serving as Resource Person on Male Contraceptives will be Ralph J. Holloway, M. D., Attending Urologist, Herbert J. Thomas Memorial Hospital, South Charleston.

Friday Evening

Concurrent sessions will be held at 8 P.M. Friday. Dr. Harry S. Weeks, Jr., of Wheeling, President of the West Virginia Medical Institute, Inc., will preside at the Physicians' Session, to be held in the Andrews Room.

"Your Educational Payoff from Medical Audit" will be the topic of William F. Jessee, M. D., of Baltimore, while Mr. Charles R. Lewis of Charleston, Executive Secretary of the State Medical Association, will follow with "Your Stake in Pending State Legislation."

Doctor Jessee is Assistant Dean for Continuing Medical Education at the University of Maryland School of Medicine.

Mrs. John M. Hartman Designer Of New Journal Cover

The new cover which was introduced this month for *The Journal* was designed by Mrs. John M. (Dolly) Hartman of Charleston.

Mrs. Hartman, whose husband is an Associate Editor of *The Journal,* was an art major in college. Her design was selected by the Publication Committee over two others submitted.

The Publication Committee and the staff of the State Medical Association are grateful to Mrs. Hartman, who volunteered her time and effort in preparing the new cover.

The other session, a public program on "Birth Control and Estrogen Update," will be held in the Wertz Ballroom, with Doctor White again presiding. In addition to the Friday afternoon speakers and topics, Dr. Patrick C. Williams, Jr., of Charleston will speak on "The DES Story." Doctor Williams is Clinical Assistant Professor of Obstetrics and Gynecology, Charleston Division, WVU.

Doctor Holloway again will serve as Resource Person on Male Contraceptives.

Saturday Morning

"Behavioral Medicine and Psychiatry Update" will be the title of the Saturday morning session, beginning at 9:30. Presiding will be Dr. Mildred Mitchell-Bateman of Huntington, Professor and Chairman, Department of Psychiatry, Marshall University School of Medicine.

The speakers will be John J. Schwab, M. D., Louisville, Kentucky, Professor and Chairman, Department of Psychiatry and Behavioral Sciences, University of Louisville, on "The Use of Psychiatric Consultation for the Practitioner;" Arthur E. Kelley, M. D., Fellow in Child Psychiatry, Department of Behavioral Medicine and Psychiatry, Charleston Division, WVU, "The Use of Psychtropic Drugs with Children," and Paul L. Crawford, Ph. D., Institute, Professor and Chairman, Department of Psychology, West Virginia State College, and Clinical Professor of Behavioral Medicine and Psychiatry, Charleston Division, WVU, "Medical Applications of Biofeedback."

Saturday Afternoon

A "Symposium on Infections" will be held Saturday afternoon, with Dr. Robert H. Waldman, Morgantown, Professor and Chairman, Department of Medicine, WVU, presiding.

The speakers and their topics will be "Diagnosis and Management of Hepatitis"—Warren Point, M. D., Professor and Director of Medicine, Charleston Division, WVU; "How to Win Friends and Influence People in the Microbiology Laboratory"—Charles W. Stratton, M. D., Assistant Professor of Medicine, Charleston Division, WVU, and Chief, Microbiology-Serology Section, Charleston Area Medical Center, and "What You Always Wanted to Know About Legionnaire's Disease"—H. Bradford Hawley, M. D., Assistant Professor of Medicine, Charleston Division, WVU, and Chief, Infectious Disease Section, CAMC.

Saturday Evening

A cash bar (beginning at 7 o'clock) and dinner will be held Saturday evening in the ballroom. Presiding will be Dr. Charles E. Andrews of Morgantown, Professor of Medicine and Provost for Health Sciences, WVU Medical Center.

Dr. George E. Pickett, State Health Director, will speak on "Changing Medical Care."

Sunday Morning

The speakers and topics for the Sunday morning session, "Medical Potpourri," will be "Drug-Drug Interactions—A Pandora's Box"—Robert H. Hoy, Pharm. D., Assistant Professor of Clinical Pharmacy, School of Pharmacy, Charleston Division, WVU; "Use of Dialysis in Acute Situations"—Mary Lou Lewis, M. D., Medical Director, Kidney Dialysis Unit, CAMC, and Clinical Associate Professor of Medicine, Charleston Division, WVU, and "What's New in Ophthalmology?"—Arthur C. Chandler, Jr., M. D., Durham, North Carolina, Associate Professor of Ophthalmology, Duke University School of Medicine.

Dr. Maurice A. Mufson of Huntington, Chairman, Department of Medicine, Marshall University School of Medicine, will preside.

Preceding the Sunday morning session, there will be an 8 A.M. breakfast meeting of the State Medical Association's Cancer Committee in the Dining Room.

Doctor Jessee In Pediatrics, Preventive Medicine

In addition to his continuing medical education post at the University of Maryland School of Medicine, Doctor Jessee is Assistant Professor of Social and Preventive Medicine. He also is Clinical Assistant Professor in Community Medicine and International Health at Georgetown University School of Medicine, and is in the part-time private practice of pediatrics in Marlow Heights, Maryland.

From July, 1973, to June, 1976, Doctor Jessee held several positions with the federal government's Bureau of Quality Assurance, Health Systems Agency, United States Public Health Service, and Department of Health, Education and Welfare. These included Special Assistant to the Director; Deputy Director, Division of Peer Review, and Acting Chief, Health Care Review Program, Division of Peer Review.

A native of Bristol, Virginia, he was graduated from Stanford University in California (with distinction and departmental honors in Biological Sciences), and received his M. D. degree in 1972 from the University of California

School of Medicine at San Diego. He is a candidate for an MPH degree this coming May from Johns Hopkins University.

He completed a residency in pediatrics at Indiana University Hospitals in 1972-73, and currently is a resident in General Preventive Medicine at the University of Maryland.

Doctor Jessee is a recipient of the American Medical Association Physician's Recognition Award, 1975, and the Resident's Honor Award, Indiana Academy of Pediatrics, 1973.

His memberships include those in the Alliance for Continuing Medical Education (and its Task Force on CME Nonparticipation), American Association of Professional Standards Review Organizations, Association for Behavioral Sciences and Medical Education, Baltimore City PSRO, and Society of Medical College Directors of Continuing Medical Education.

He also is a member of the Advisory Committee, Community Center for Continuing Education, Baltimore; Consultant in Medical Audit and Continuing Medical Education, Montgomery County (Maryland) Heart Association, member of the House of Delegates, American Association of PSROs: Director of Program Development, Baltimore City PSRO, and President and Chairman, Medical Care Evaluation Systems, Inc.

Doctor Jessee is the author or co-author of some 20 medical and related publications.

Other Conference Information

Serving on the Program Committee are Drs. Ralph H. Nestmann and Joseph T. Skaggs, both of Charleston, Co-Chairmen; and William O. McMillan, Jr., of Charleston, and C. Carl Tully of South Charleston.

A registration fee of $20 for the entire conference, including the Saturday evening dinner, will be charged to all registrants except nurses, medical students, interns and residents.

All extra tickets (not included in the registration fee) for the dinner session Saturday evening must be purchased by 10 A.M. on that day. Such tickets ($7.50 each) would include those for spouses and other guests—and for nurses, medical students, interns and residents.

These tickets will be available at the registration desk beginning with registration Friday afternoon.

All other registrants paying the $20 fee will receive their dinner tickets when they register at the conference.

Continuing Education Activities

Here are the continuing medical education activities listed primarily by the West Virginia University School of Medicine for part of 1978, as compiled by Dr. Robert L. Smith, Assistant Dean for Continuing Education. The schedule is presented as a convenience for physicians in planning their continuing education program. (Other national, state and district medical meetings are listed in the *Medical Meetings* Department of *The Journal.*)

The program is tentative and subject to change. It should be noted that weekly conferences also are held on the Charleston and Wheeling campuses as well as in Morgantown. Further information about these may be obtained from: Division of Continuing Education, WVU Medical Center, P. O. Box 2867, Charleston 25330; Office of Continuing Medical Education, WVU Medical Center, Morgantown 26506; or, Office of Continuing Medical Education, Wheeling Division, WVU School of Medicine, Ohio Valley Medical Center, 2000 Eoff Street, Wheeling 26003.

Feb. 20-24	Morgantown	Family Practice Review Course
Mar. 11	Morgantown	Annual Conjoint Behavioral Medicine—Internal Medicine Day
Mar. 17, 18	Morgantown	Cancer Teaching Days—Pediatric Oncology
Mar. 24	Charleston	Fifth Annual Newborn Day
Mar. 25	Wheeling	Seminar on Surgical Problems

Council Hears Doctor Picket During Fall Meeting

The West Virginia State Medical Association's Council worked its way through a heavy agenda, including a discussion with George E. Pickett, M. D., the new State Director of Health, at its fall meeting in Charleston November 20.

It was Doctor Pickett's first opportunity to meet with the Council since he assumed the health position September 1, and major attention was focused on views he expressed in earlier

prepared addresses and newspaper interviews regarding development of a national health service in coming years as—in his opinion— the "only complete way to guarantee the right of access (to needed medical care) and contribute to the nation's health."

Council invited Doctor Pickett, during the course of the discussion, to prepare material for publication in an upcoming issue of *The West Virginia Medical Journal* to clarify some points about which he felt public and other misunderstanding had developed.

In other action, the Council:

—Took formal note, with a moment of silence, of the death of James S. Klumpp, M. D., Association President in 1953 and long-time Parliamentarian, in Huntington on October 26.

—Approved for the 1978 calendar, and budget, year a $275,815 operating budget, exclusive of $18,000 earmarked for medical scholarships.

—Reappointed Stephen D. Ward, M. D., of Wheeling, the current Chairman and Editor of the Medical Journal, to a new seven-year term as a member of the Publication Committee, effective January 1, 1978; and adopted a resolution commending the Medical Association staff for "its devotion to the highest standards of editorial skill and workmanship in editing and publishing *The Journal* of the West Virginia State Medical Association."

—Approved the issuance or reissuance of charters to Cabell, Kanawha, Marion, Logan, Greenbrier Valley, Monongalia and Mingo County Medical Societies.

—Reappointed, as nucleus members of the Board of the West Virginia Medical Political Action Committee, Doctor Ward in the First Congressional District; N. B. Groves, M. D., Martinsburg, Second District; Joseph T. Skaggs, M. D., Charleston, Third District; Frank J. Holroyd, M. D., Princeton, Fourth District; Jack Leckie, M. D., Huntington, ex officio member representing Council; and Charles R. Lewis, Charleston, the Association's Executive Secretary, also as an ex officio member.

—Endorsed Medical Association participation in two adventures, each offering medical education seminars, planned by INTRAV of St. Louis, with one involving a March 2-11, 1978, trip to Peru and Ecuador, and second calling for an Imperial European Adventure visiting Vienna, Budapest and Dubrovnik in the fall of 1978.

—Directed the Association leadership to consider questions raised by the Mercer County Medical Society relative to multiple utilization review programs established by third parties; and to take appropriate action.

—Heard a presentation by Dr. R. John C. Pearson, Chairman of the Department of Community Medicine at the West Virginia University Medical Center, and members of the Health Services Research staff at WVU, relative to development of rural clinics in the state in the 1970s. Council directed that Joseph A. Smith, M. D., the Association's President, name a committee to work with Doctor Pearson and the research staff toward establishment of a physician recruitment and placement service for rural West Virginia.

Mr. Lewis reported to Council on a number of matters, including (1) continued efforts to assist the Workmen's Compensation Fund in filling a medical consultant vacancy; (2) initial work with the Committee on Medical Scholarships to bring students accepted by the new Marshall University Medical School into the Association's scholarship program; and (3) preliminary work by the Committee on Constitution and By-Laws toward providing for medical student membership in the Medical Association.

Mr. Lewis also reported that with the departure of Martha Jane Coyner, M. D., Harrisville, from West Virginia, John Mark Moore, M. D., of Wheeling had been designated by Doctor Smith as Chairman of the Committee on Medical Scholarships, with William E. Gilmore, M. D., of Parkersburg appointed to the committee by Doctor Smith.

Doctor Belis Receives Urology Award

Dr. John A. Belis of Morgantown has been named an American Urological Association Scholar for a two-year period which began this month.

To encourage and fund basic science research in urology, the Association makes four such awards each year to physicians who have completed their specialty training in urology. Doctor Belis just completed his residency in that specialty at West Virginia University and joined the School of Medicine faculty this month as Assistant Professor of Surgery in the Division of Urology. Among his research interests is prostatic cancer.

Doctor Belis is a graduate of Jefferson Medical College in Philadelphia. After two years of general surgery training at Dartmouth-Hitchcock Medical Center in Hanover, New Hampshire, he was a N.I.H. urology research fellow at WVU for one year in addition to his three-year urology residency.

Doctor Leckie Named To SMA Council

Dr. Jack Leckie of Huntington has been elected as a Councilor to the Southern Medical Association.

Doctor Leckie, a family physician and President of the State Medical Association in 1975-76, is on the staff of St. Mary's Hospital in Huntington. He has served for the past decade as a member of the hospital's Executive Committee and as Director and Chairman of the Emergency Room Service.

A life member of the SMA, he has served for two terms as Chairman of the Family Practice Section.

Meanwhile, Dr. M. Bruce Martin, also of Huntington, recently completed service as an SMA Councilor.

Doctor Klumpp, Past President, Dies In Huntington

Dr. James S. Klumpp of Huntington, President of the West Virginia State Medical Association in 1953, died on October 26 in a hospital there. He was 84.

A resident of Huntington since 1919, Doctor Klumpp was a retired surgeon and retired Captain in the U. S. Navy Medical Corps. He retired from active practice in 1957 because of injury and illness.

In more recent years (1966 to 1973), Doctor Klumpp had served as Parliamentarian for the State Medical Association. He also served as a member of the Association's Council, and was a former Chairman of the Association's Committee on Constitution and Bylaws. He was President of the Cabell County Medical Society in 1947.

James S. Klumpp, M. D.

A native of Owosso, Michigan, he was graduated from the University of Michigan and received his M. D. degree in 1920 from that institution's Medical School. He interned at Guthrie Hospital in Huntington, beginning practice in that city in 1922.

Doctor Klumpp was a Fellow of the American College of Surgeons and the International College of Surgeons, and was an honorary member of the Cabell County Medical Society, the West Virginia State Medical Association and the American Medical Association.

A past Elder of the Enslow Park Presbyterian Church in Huntington, he was preceded in death by his wife, Reba Griffith Klumpp, in 1970.

He was a veteran of both World War I and World War II, serving in all three theaters of operation during World War II.

Survivors include one daughter, Mrs. Mary Alice Cunningham of Huntington, and two sisters, Mrs. Alice Spitler of Chelsea, Michigan, and Mrs. Florence Haist of Saginaw, Michigan.

AAFP Workshops To Aid In Taking Exams

The American Academy of Family Physicians will hold workshops to assist practicing family doctors to take the certifying examination in family practice.

The series of eight workshops, to be held January through March at various sites, are designed specifically to help doctors prepare for the upcoming examination in August. The 1978 examination will be the last one for which family doctors who have not completed a family practice residency may be eligible. Subsequent examinations will be open only to physicians who have completed an approved residency training program.

According to Dr. Tom Stern, Director of the AAFP Education Division, the workshop will provide information on testing techniques similar to those used for the board examination scheduled in August. He noted that these workshops will be similar to the continuing education programs on the subject conducted at the recent AAFP Scientific Assembly in Las Vegas. He added that it is important that prospective examinees be aware that the cutoff date to apply to take the examination is April 1.

Advance registration is necessary to attend the workshops. For further information, write Education Division, American Academy of Family Physicians, 1740 West 92nd Street, Kansas City, Missouri 64114, or call 800-821-2512. A fee of $50 will be charged to offset expenses.

The dates and sites of the workshops are:

January 7, Atlanta Hilton, Atlanta.

January 8, American Inn of the Six Flags, Arlington, Texas.

February 24, Sheraton Denver Airport Hotel, Denver.

February 25, Thunderbird Jantzen Beach Motor Hotel, Portland, Oregon.

February 26, Century Plaza, Los Angeles.

March 3, Sheraton Airport Inn, Philadelphia.

March 4, Radisson South, Bloomington, Minnesota.

March 5, Hyatt Regency O'Hare, Chicago.

Behavioral-Internal Medicine Course In Morgantown

Annual Behavioral Medicine-Internal Medicine Day is scheduled for March 11 at the West Virginia University Medical Center in Morgantown from 9 A.M. through 4:30 P. M.

The opening session on "Therapy Update" will include the following topics and speakers:

"Vasodilator Treatment of Congestive Heart Failure"—Willard Harris, M. D., and Carl Heltne, M. D.; "Management of Peptic Ulcer Disease"—William Anderson, M. D., and "Beclomethasone in the Management of Asthma"—David Hendrick, M. D.

Also scheduled for the morning session are:

"The Current Role of CAT Scanning"—Orlando Gabriele, M. D.; "Nephrotoxic Antibiotics"—Ronica Kluge, M. D., and Management of Chronic Renal Insufficiency, Jovan Milutinovich, M. D.

The afternoon session will begin with a discussion of "Depression and Pseudodementia." Speaking will be William Hobbs, M. D., on "Diagnostic Clues to Depression;" Shawn Chillag, M. D., "Investigation and Differentiation," and David Withersty, M.D., "Management of Depression."

The remaining afternoon program will include:

"Practical Management of Headache"—John Mateer, M. D.; "Management of Persons Having Previous Head and Neck Radiation"—Phillip Peters, M. D.;

"Hematological Consequences of Drug Therapy"—John Rogers, M. D., and "Evaluation of TB Skin Test and Chemoprophylaxis"—Keith Morgan, M. D.

Dr. Robert Waldman will be the morning moderator, with Dr. Irma Ullrich moderating in the afternoon.

Doctor Procurement Committee Formed By Marion Society

A Doctor Procurement Committee has been appointed by the Marion County Medical Society to deal with the acute doctor shortage in Fairmont and Marion County.

Dr. Joseph D. Romino of Fairmont, President, announced at a recent meeting of the Society that several doctors have been contacted by the committee and by individual physicians.

"Several of those contacted have expressed interest in locating here and all were impressed by the hospital facilities," Doctor Romino reported.

Guests at the meeting included Marion County students presently enrolled in the West Virginia School of Medicine. The students were urged to consider their home county when deciding on a location in which to practice.

Cancer Teaching Days At WVU In March

The annual Cancer Teaching Days will be held on March 17 and 18 at the West Virginia University Medical Center in Morgantown.

The topic of the postgraduate course this year will be "Pediatric Oncology."

The program will be conducted on Friday, March 17, from 9 A.M. to 4:30 P. M. The speakers and their topics will include:

"Children at High Risk for Developing Cancer"—Brigid Leventhal, M. D.; "Immunologic Aspects of Pediatric Tumors"—Jesse Jenkins, M. D.; "Cure of Leukemia"—Mark E. Nesbit, Jr., M. D.;

"Neuroblastoma"—E. Thomas Boles, Jr., M. D.; "Wilm's Tumor"—Stanley Kandzari, M. D., and "Classifications of Lymphomas"—Sheila Shah, M. D.

The Saturday program will be held from 9 A. M. through 12:15 P. M., with the following speakers and topics:

"Radiotherapy in Multi-Modality Clinical Trials: Present Status and Future Goals"—Melvin Tefft, M. D.; "Late Effects of Cancer Therapy"—Doctor Nesbit, and "Emotional Support of Families of Children with Cancer"—Doctor Leventhal.

Review A Book

The following books have been received by the Headquarters Office of the State Medical Association. Medical readers interested in reviewing any of these volumes should address their requests to Editor, *The West Virginia Medical Journal*, Post Office Box 1031, Charleston 25324. We shall be happy to send the books to you, and you may keep them for your personal libraries after submitting to *The Journal* a review for publication.

General Ophthalmology, 8th Edition, by Daniel Vaughan, M. D., and Taylor Asbury, M. D. 379 pages. Price $12. Lange Medical Publications, Los Altos, California 94022. 1977.

Handbook of Obstetrics & Gynecology, 6th Edition, by Ralph C. Benson, M. D. 722 pages. Price $9.50. Lange Medical Publications, Los Altos, California 94022. 1977.

The Nervous System, by W. F. Ganong, M. D. 226 pages. Price $8. Lange Medical Publications, Los Altos, California 94022. 1977.

Current Surgical Diagnosis and Treatment, 3rd Edition, by J. Engelbert Dunphy, M. D.; Lawrence W. Way, M. D., and associate authors. 1139 pages. Price $18. Lange Medical Publications, Los Altos, California 94022. 1977.

Review of Medical Physiology, 8th Edition, by William F. Ganong, M. D. 559 pages. Price $12.50. Lange Medical Publications, Los Altos, California 94022. 1977.

Handbook of Pediatrics, 12th Edition, by Henry K. Silver, M. D.; C. Henry Kempe, M. D., and Henry B. Bruyn, M. D. 723 pages. Price $9. Lange Medical Publications, Los Altos, California 94022. 1977.

Medicolegal Aspects of Hospital Records, Second Edition, by Emanuel Hayt, LL. B. 519 pages. Physicians' Record Company, 3000 South Ridgeland Avenue, Berwyn, Illinois 60402. 1977.

Southeastern Surgical Congress In February, New Orleans

New developments in major areas of surgery will be spotlighted at the 46th annual assembly of the Southeastern Surgical Congress, February 19-22, at the Fairmont Hotel in New Orleans.

Some 2,000 surgeons, surgical nurses and medical and nursing students are expected to attend, according to Dr. Thad M. Moseley of Jacksonville, President; and Dr. A. Hamblin Letton of Atlanta, Director.

The 13 Southeastern states, District of Columbia and Puerto Rico will be represented.

Nationally-known surgeons invited as guest speakers are: Dr. Oliver H. Beahrs, Head of Surgery, Mayo Medical School and Clinic; Dr. Hiram C. Polk, Jr., Chairman, Department of Surgery, University of Louisville School of Medicine; Dr. Erle E. Peacock, Jr., Chairman, Department of Surgery, Tulane University School of Medicine; Dr. Robert E. Hermann, Staff Surgeon, the Cleveland (Ohio) Clinic; and Col. (Dr.) Basil A. Pruitt, Jr., Director, Army Institute of Surgical Research, Brooke Army Medical Center, Ft. Sam Houston, Texas.

Dr. Alexander Heard, Chancellor of Vanderbilt University, will address the opening session.

Dr. John L. Ochsner, Director of New Orleans Ochsner Clinic, is coordinating the nurses' educational program to run concurrently with the surgeons' scientific sessions.

A postgraduate course for surgeons on "Infections" will be chaired by Dr. William R. Sandusky of the University of Virginia Medical School. Both scientific and postgraduate sessions are accredited for the American Medical Association's continuing education award.

Dr. Watts R. Webb of New Ordeans is chairman of local arrangements.

Saccharin Warning Labels Due By February

Following President Carter's signing of the Saccharin Study and Labeling Act on November 23rd, the Food and Drug Administration was acting to insure that a cancer warning will appear on all retail packages of saccharin and all packages of food containing saccharin within the 90 days required by the new law.

The Congressionally-mandated label warning must say:

"Use of this product may be hazardous to your health. This product contains saccharin which has been determined to cause cancer in laboratory animals."

In addition to requiring the label warning, the new law puts an 18-month moratorium on regulatory action by FDA to remove saccharin from the market. The FDA had proposed a ban on saccharin in foods in April following the receipt of a Canadian study which, along with other evidence, confirmed that saccharin causes cancer in laboratory animals.

FDA Commissioner Donald Kennedy said: "All the available evidence demonstrates that saccharin can cause cancer in test animals, and we have every reason to believe that it also causes cancer in people. It is essential that the public understand the risks associated with the use of saccharin-containing products so that they can make an informed choice in the marketplace. We urge manufacturers to put this warning on their products as quickly as possible."

Johns Hopkins Physician Receives AAP Award

George G. Graham, M. D., Professor of Nutrition at the Johns Hopkins School of Hygiene and Public Health, was chosen by the American Academy of Pediatrics to receive the 1977 Borden Award gold medal and $1,000 for his significant contributions to human nutrition, with particular emphasis on the infant and young child.

The Borden Award, initiated in 1944 to honor outstanding achievement in research related to infant nutrition and/or the development of children, is made possible by funds provided by the Borden Company Foundation. It is open to residents of the United States and Canada.

Doctor Graham has devoted most of his professional career to the study of human nutrition. He has been a leader in the treatment and prevention of malnutrition among children in developing countries through the use of proteins of different quality. His studies of the interdependence of protein and energy intakes are models of scientific design. He and his colleagues were the first to describe the syndrome of copper deficiency in young infants.

Doctor Graham's expertise is acknowledged in both North and South America. In addition to his post at Johns Hopkins as a nutritionist, he is also Director of the Nutrition Program of the Johns Hopkins School of Hygiene and Public Health. He is Past Chairman of the Nutrition Study Section, National Institutes of Health, and a former member of the Committee on Aquatic Food Resources of the National Research Council. He received his M. D. degree in 1945 from the University of Pennsylvania and took his internship and first year of residency at the British American Hospital in Lima, Peru.

Doctor Graham received his award at the annual meeting of the American Academy of Pediatrics in New York City in November.

Medical Meetings

Jan. 23-25—Society of Thoracic Surgeons, Orlando, Fla.

Jan. 27-29—11th Mid-Winter Clinical Conference, Charleston.

Feb. 3-5—74th Congress on Medical Education, Chicago.

Feb. 8-12—American College of Psychiatrists, New Orleans.

Feb. 13-16—The Management of Obesity (Dept. of Psychiatry, Johns Hopkins U. School of Med.), Baltimore.

Feb. 19-20—Southeastern Surgical Congress, New Orleans.

Feb. 22-26—Am. Assn. of Genito-Urinary Surgeons, Key Largo, Fla.

Feb. 22-26—Am. College of Nuclear Physicians, San Francisco.

Feb. 23-28—Am. Academy of Orthopaedic Surgeons, Dallas.

March 2-4—International Congress on Colonoscopy and Diseases of Large Bowel, Miami Beach.

March 6-9—Am. College of Cardiology, Anaheim, Calif.

March 10-15—Am. Society of Abdominal Surgeons, Las Vegas.

March 13-16—ACS, Cincinnati.

March 29—April 1—Am. Fertility Society, New Orleans.

April 5-6—W. Va. Chapter, Am. Academy of Pediatrics, Wheeling.

April 7-9—W. Va. Chapter, AAFP, Charleston.

April 24-29—Am. Academy of Neurology, Los Angeles.

April 26-29—W. Va. Academy of Ophthal. & Otolaryn., White Sulphur Springs.

May 3-6—W. Va. Chapter, ACS, White Sulphur Springs.

June 10—W. Va. State Society of Anesthesiologists, Morgantown.

June 17-22—AMA Annual Meeting, St. Louis.

Aug. 23-26—111th Annual Meeting, W. Va. State Medical Assn., White Sulphur Springs.

Nov. 11-14—Southern Medical Assn., Atlanta.

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THE PROGRAM CO-CHAIRMEN again are Ralph H. Nestmann, M. D., and Joseph T. Skaggs, M. D., both of Charleston. Also on the Program Committee are William O. McMillan, Jr., M. D., of Charleston, and C. Carl Tully, M. D., of South Charleston.

THE REGISTRATION FEE of $20 for the entire conference, including the Saturday night dinner, will be charged all registrants except nurses, medical students, interns and residents. Dinner tickets for the latter registrants, spouses and other guests will be available at the registration desk. Advance registration is requested, and please make checks payable to "WEST VIRGINIA STATE MEDICAL ASSOCIATION."

ACCREDITATION: Attendance will be acceptable for 12 hours of Category 1 credit toward the Physician's Recognition Award of the American Medical Association; and the program also is acceptable for 12 prescribed hours by the American Academy of Family Physicians.

OVERNIGHT ACCOMMODATIONS: Physicians should communicate directly with the reservation manager of the hotel or motor inn of their choice, with the conference headquarters hotel setting aside rooms for registrants.

FOR ADVANCE REGISTRATION, please complete the form below and mail to: WEST VIRGINIA STATE MEDICAL ASSOCIATION, P. O. BOX 1031, CHARLESTON, W. VA. 25324.

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WVU Medical Center
—News—

Compiled from material furnished by Mrs. Mary Ellin Wylie, Director, Medical Center News and Information Services, Morgantown, W. Va.

Isoprinosine Shows Promise Against Colds, Influenza

Viral infections are hard to fight because viruses are notoriously resistant to medication, but WVU researchers believe an experimental drug may provide a new weapon against colds and influenza.

It's called isoprinosine and it shows promise of being a broad-spectrum drug active against a number of viral infections, effective even when given after disease symptoms appear. It has no serious side effects.

WVU infectious disease specialists working with isoprinosine are cautious in their evaluations. They say only that tests by them and other medical researchers indicate the drug alleviates symptoms and shortens the course of influenza and may also be effective against head colds and herpes infections.

Its action differs from immunization, which has been of some help against influenza. Such vaccines must be given before the disease strikes and new vaccines have to be constantly developed because of the changing character of the viruses.

Isoprinosine has been under investigation for several years. A research report from the University of Munich described a dramatic recovery following administration of isoprinosine to a 13-year-old German boy suffering from subacute sclerosing panencephalitis (SSPE). SSPE, which is rare, is thought to be a complication of measles virus infection.

Independent studies are continuing in a number of medical schools to establish the drug's efficiency as a virus fighter. These studies are being funded by Newport Pharmaceuticals International of California, manufacturers of the drug.

The WVU researchers—Drs. Robert H. Waldman, Rashida Khakoo and Rama Ganguly—first became involved in testing the drug while on the faculty of the University of Florida College of Medicine. Doctor Waldman became Professor and Chairman of the WVU Department of Medicine in July, 1976, and his research associates joined the faculty as assistant professors in the WVU Division of Infectious Diseases six months later.

Their tests of the drug's effectiveness against influenza A virus were reported this fall at the 10th International Congress of Chemotherapy in Zurich, Switzerland, and at the Interscience Conference on Antimicrobial Agents and Chemotherapy in New York.

Stimulates Immune System

Tests results indicate the drug stimulates the immune system, Doctor Khakoo said. "Other studies had shown a rise in antibody level," she explained, "but we didn't observe this. Rather, isoprinosine, by some mechanism which we don't fully understand, seems to stimulate the cell-mediated immune system."

Antibodies against a specific disease result from previous infection or immunization and are responsible for prevention. Cell-mediated immunity is believed to bring about recovery.

During the study, 41 healthy young adult volunteers were divided into three groups. All were exposed to a mild influenza type A virus.

The control group received a placebo, the therapeutic group received isoprinosine two days following exposure, and the prophylactic group received the drug 48 hours before exposure.

The identity of the control group and those receiving medication was unknown to the investigators until completion of the study.

Both groups receiving isoprinosine did better than the control group. Those given it after exposure to the virus did slightly better in regard to some symptoms than those who had taken it before.

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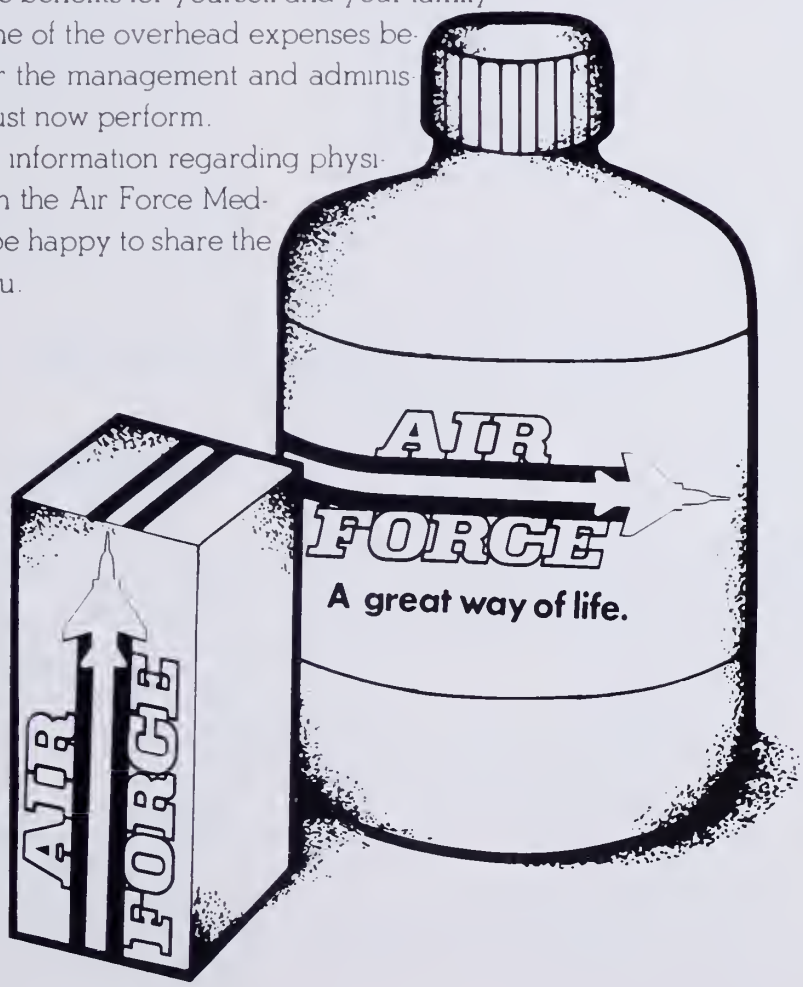

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Third-Party News, Views and Program Concerns

Vaccine Against Pneumonia Licensed By FDA

The Food and Drug Administration recently announced it has licensed a vaccine against pneumococcal pneumonia, a common form of pneumonia.

There are no other vaccines on the market to prevent this form of bacterial pneumonia, which is a serious and sometimes fatal lung infection.

A similar, but less broadly effective, pneumonia vaccine was developed in the 1940s under the sponsorship of the Armed Forces, but its use was abandoned and further research ended since it was generally assumed at that time that antibiotics would solve the pneumonia problem.

Despite the wide use of antibiotics, however, pneumonia today is the fifth leading cause of death in the United States, killing an estimated 25,000 Americans annually. The type of pneumonia against which the vaccine protects accounts for a major portion of these deaths. The vaccine is effective in at least 80 per cent of the people who receive it.

The company which has been licensed by FDA to sell the vaccine, Merck, Sharp & Dohme, West Point, Pennsylvania, expects to begin commercial distribution early this year. The brand name of the vaccine is "Pneumovax" (polyvalent pneumococcal vaccine).

The vaccine is expected to be particularly useful for the elderly and for people over the age of 2 with serious chronic diseases, since these groups face an increased risk of dying from pneumonia.

Pneumonia is not generally fatal in healthy young adults and children in the United States, and these groups are not considered prime targets for the vaccine.

The incidence of pneumonia increases under crowded conditions, so the vaccine also is expected to be used in nursing homes and other institutions.

Preliminary studies suggest that the vaccine also is useful in sickle cell anemia patients, since they are at especially high risk from severe pneumonia infections. Studies also are under way to determine the effectiveness of the vaccine in preventing middle ear infection in infants.

Reactions to the vaccine, such as soreness and redness at the injection site, are common, but usually last no longer than 48 hours.

Since the vaccine is entirely derived from inactivated or killed bacteria, the vaccine itself cannot cause pneumonia.

The vaccine was developed at the Merck, Sharp & Dohme Research Laboratories under the direction of Dr. Maurice Hilleman, working in cooperation with Dr. Robert Austrian of the University of Pennsylvania and investigators supported by the National Institutes of Health.

Field trials of the vaccine, involving some 30,000 volunteers, began in 1973.

8,100 Home Furnace Injuries In U.S. Last Season

Last winter, approximately 6,500 consumers in this country received hospital emergency room treatment for injuries associated with central furnaces and 1,600 received treatment for floor furnace accidents, according to a recent issue of "State of the State's Health," a publication of the West Virginia State Department of Health.

Furnace accidents that can occur and should be avoided are: contact with hot metal grates and other hot surfaces, carbon monoxide poisoning (all fuel-burning appliances need air in order to burn the fuel properly), and ignition of accumulated fuel vapors.

During last season, 6,000 people received emergency room treatment for injuries associated with fireplaces; and 5,000 persons received treatment for space heater and wood and coal-burning stove injuries.

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Obituaries

D. BROWN BARBER, M. D.

Dr. D. Brown Barber, a lifelong resident of Charleston, died suddenly on November 23 in a hospital there. He was 51.

A family physician, Doctor Barber was a Board member at the Kanawha Valley Memorial Hospital in Charleston.

He was graduated from the University of Chicago and West Virginia University, receiving his M. D. degree in 1957 from the Medical College of Virginia.

A veteran of the Navy, he was a member of the Kanawha Medical Society, the West Virginia State Medical Association and the American Medical Association.

Surviving are the widow; two sons, Danny and David Barber, at home; a daughter, Martha Barber, at home; the parents, Dr. and Mrs. Daniel N. Barber of Charleston, and two brothers, Timothy M. Barber of Charleston and Dr. James David Barber of Durham, North Carolina.

* * *

CHARLES F. FISHER, M. D.

Dr. Charles F. Fisher of Houston, Texas, formerly of Clarksburg and Parkersburg, died on November 21 in Parkersburg following an unexpected illness. He was 77.

A native of Parkersburg, Doctor Fisher, a surgeon, practiced in Clarksburg from 1929 until 1972, when he retired and moved to Houston.

Doctor Fisher was graduated from St. John's College in Annapolis, Maryland, and received his M. D. degree in 1921 from the University of Maryland School of Medicine in Baltimore.

He served his internship and residency at University Hospital in Baltimore, and later did postgraduate work at the Cleveland Clinic and in Germany and Switzerland.

He was admitted to practice in West Virginia in 1923 and was located in Richwood until going to Clarksburg.

Doctor Fisher was an honorary member of the Harrison County Medical Society, the West Virginia State Medical Association and the American Medical Association.

He was a Fellow of the Southeastern Surgical Congress, the American College of Surgeons, and the International College of Surgeons.

A colonel with the U. S. Army Medical Corps from 1942 to 1946, he was stationed in North

(Continued on page xviii)

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OBITUARIES—Continued from page xvi

Africa, Italy, Okinawa and Japan. He received the Legion of Merit in 1945. He was an honorary member of the Medical and Surgical Society of Naples, Italy, and, in 1944, received an honorary A. B. degree from the University of Naples.

Survivors include the widow; two daughters, Mrs. Glen Dorflinger of Houston and Mrs. Harold Booth of Gainsville, Florida; one brother, Richard Fisher of Sun City, Arizona, and one sister, Mrs. Anna Pence of Parkersburg.

* * *

JUAN A. NORDELO, M. D.

Dr. Juan A. Nordelo of Man died on November 11 at his home there. He was 51.

Doctor Nordelo was President of the staff and Chief of Obstetrics and Gynecology at Man Appalachian Regional Hospital.

A native of Cuba, he received his M. D. degree in 1955 from the University of Havana School of Medicine. He completed postgraduate work at several locations in this country, including Louisville, Kentucky.

Doctor Nordelo was a member of the Logan County Medical Society, of which he was Secretary-Treasurer in 1970, and the West Virginia State Medical Association.

Survivors include the widow; a daughter, Kelly Nordelo, at home; two sons, Juan C. Nordelo of Union City, New Jersey, and Kim A. Nordelo, at home; and three brothers, Gustavo Nordelo of Belle Glade, Florida; Eduareo Nordelo of West Palm Beach, Florida, and Jose A. Nordelo of Cuba.

* * *

D. DALLAS HAMILTON, M. D.

Dr. D. Dallas Hamilton of Mannington, Marion County's oldest practicing physician, died on September 25 in a Fairmont Hospital. He was 79.

Doctor Hamilton, a former Mayor of Mannington, was graduated from West Virginia University and received his M. D. degree in 1925 from Eclectic Medical College in Cincinnati.

A veteran of World War I, Doctor Hamilton was an honorary member of the Marion County Medical Society, the West Virginia State Medical Association and the American Medical Association, and was a member of American College of Physicians, American College of Surgeons, and Southern Medical Association.

Survivors include the widow; a son, Dr. Thomas M. Hamilton of Fargo, North Dakota, and a daughter, Mrs. Randolph Walthall of Sacramento, California.

County Societies

CABELL

The Cabell County Medical Society met on November 10 at the Gateway Inn in Barboursville.

The speaker was Z. Erik Farag, Ph. D., of Charleston, Governor Rockefeller's Special Assistant for Health Affairs. Doctor Farag discussed the future of the health care system in West Virginia, and then answered questions.

The Society observed a moment of silent tribute to the late Dr. James S. Klumpp of Huntington who died on October 26.—Colin M. Craythorne, M. D., Acting Secretary.

* * *

MONONGALIA

The Monongalia County Medical Society met on November 1 at the Old Mill Club in Morgantown.

The scientific program was presented by Dr. George J. Hill II of Huntington, Professor and Chairman of Surgery and Associate Dean, Marshall University School of Medicine. His topic was "Recent Advances in Management of Colon Cancer."

The Society voted to pledge $5,000 for a room at the new Monongalia General Hospital.

The Society also approved a donation of $370, representing $10 for each medical student from Monongalia County attending West Virginia University School of Medicine, to the American Medical Student Association at WVU. —Barbara Jones, M. D., Secretary.

* * *

McDOWELL

The McDowell County Medical Society met on November 9 at the home of Dr. and Mrs. Arthur A. Carr in Welch.

Guests for the evening were Dr. and Mrs. Joseph A. Smith of Dunbar. Doctor Smith, President of the West Virginia State Medical Association, gave an interesting talk on medicine in West Virginia, and then answered questions.

The Society approved a donation of $30, representing the three medical students from McDowell County, to the American Medical Student Association at West Virginia University School of Medicine.—Muthusami Kuppusami, Secretary.

MERCER

The Mercer County Medical Society met on November 21 at Frankie's La Salute Club in Princeton.

Guests included Dr. Warfield Garson, Medical Director for Consolidation Coal Company, Continental Oil, and Mr. Buck Hyler and Mr. John Hock, members of the local staff of the office of personnel management and employee relations, Consolidation Coal Company.

Doctor Carson gave a clear, concise presentation on the place of the coal industry in the United States and its plans for providing energy in the coming decades, and the position of the employer, physician and employee in the coal industry. Part of the presentation reviewed the United Mine Workers Health and Welfare Fund.

The Society voted to send a check for $100, representing 10 Mercer County students at $10 each, to the West Virginia branch of the American Medical Student Association, West Virginia University Chapter.—David F. Bell, Jr., Secretary-Treasurer.

• • •

SUMMERS

The Summers County Medical Society met on November 28 at Pipestem State Park.

Dr. and Mrs. Joseph A. Smith of Dunbar and Mr. Tom Auman of Charleston were guests. Doctor Smith, President of the West Virginia State Medical Association, discussed many of the current problems faced by organized medicine in West Virginia.

Mr. Auman, Account Supervisor, Aetna Life and Casualty Company, discussed the State Medical Association's medical malpractice insurance program, and answered questions.—Chandra P. Sharma, M. D., Secretary.

Cardiopulmonary Nuclear Medicine Course

"Recent Advances in Cardiopulmonary Nuclear Medicine: With Emphasis on Computer Application," a continuing medical education course, will be held at Cross Keys Inn, Baltimore, Maryland, and The Johns Hopkins Medical Institutions February 16-18. This course is sponsored by the Johns Hopkins University School of Medicine. The objective is to acquaint Nuclear Medicine physicians and cardiologists with the most recent advances in cardiovascular nuclear medicine techniques, especially those related to computer applications.

Answers To Review Article Questions

(Questions on Page 3)

1. False. Ninety per cent of hypertensive patients falls into the primary or essential category.

2. False. Most hypertensives can be accurately evaluated in the office or outpatient setting. Invasive diagnostic procedures and hypertensive crisis are obvious exceptions.

3. True. The K-W eye-ground changes form a visual guide of severity from mild to malignant from Grades I through IV.

4. False. The Framingham Study concluded that "congestive heart failure was a lethal phenomenon, with only 50 per cent surviving for five years."

5. False. The Joint National Committee on Detection, Evaluation, and Treatment recommends relatively few routine tests: CBC, UA, K+, glucose, cholesterol, creatinine/BUN, chest x-ray, and EKG. Any more specialized tests for the detection of secondary forms of hypertension should be performed only when specifically indicated.

6. True. This underscores the importance of a complete physical examination. When such a bruit is heard a more extensive work-up such as rapid sequence IVP, and angiograms are indicated.

7. True. In the young patient, diminished or delayed femoral pulses may indicate coarctation, while in the older patient this may be a clue to obstructive disease of the aorta or femoral arteries.

8. False. An S_3 heralds the onset of left ventricular failure which carries with it a poor prognosis. See question No. 4.

9. True. An easily correctable form of hypertension, easily diagnosed; but you must specifically ask your women hypertensives, as many women do not consider oral contraceptives as drugs.

10. True. Hence, the importance of abdominal ascultation for bruits, palpation for renal masses, and urinalysis and creatinine determinations.

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The West Virginia Medical Journal

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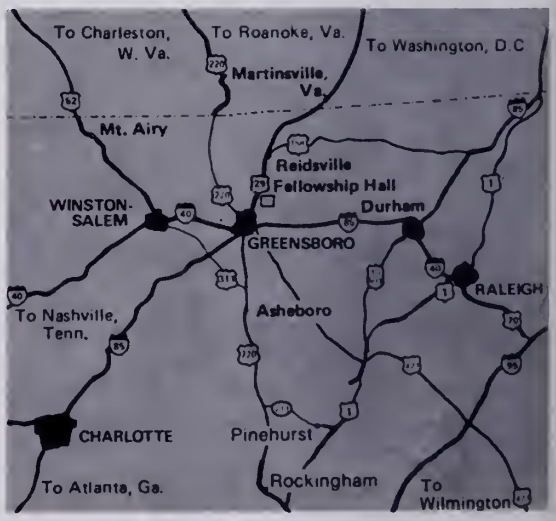

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The West Virginia Medical Journal

Vol. 74, No. 2 February, 1978

Selective Coronary Arteriography By A Percutaneous Femoral Technique At West Virginia University Medical Center

ALLEN F. BOWYER, M. D.
Director, Cardiac Catheterization Laboratory, West Virginia University Medical Center, Morgantown.

ABNASH C. JAIN, M. D.
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ROBERT J. MARSHALL, M. D.
Department of Medicine, Division of Cardiology, West Virginia School of Medicine, Morgantown.

Among new diagnostic techniques developed over the past decade, few have had the impact on medical care as great as that of selective coronary arteriography.[2,3] With this technique the medical community has accurate information on the location, severity, extent, and complicating patterns of coronary artery disease. The detailed description of this disease, formerly only available from autopsy studies, can now be obtained rapidly and safely in the intact subject. As a result, patients with non-coronary chest pain once thought to have coronary disease have been released from this serious concern, while patients with life-threatening proximal vessel disease have the option for revascularization.

The purpose of this paper is to report our experience at West Virginia University Medical Center with a selective coronary arteriographic technique in more than 1,300 patients studied during the past seven years.

> "One of the most distinguishing features of true angina is consciousness on the part of the patient, in his anguish of mind, that the very citadel of life has been approached."
> Sir William Osler, 1897.[1]

West Virginia shares in the national epidemic of coronary artery disease (CAD). The prevalence of CAD is approximately 1.88 per cent (3.9 million/212 million) nationally (Table 1) and approximately 2.39 per cent (40.5 thousand/1.7 million) for West Virginia (Table 2). Over 35 per cent of all deaths for both the state and nation are due to ischemic heart disease (IHD). Between 1971 and 1975, little variation occurred in the more than 7,100 yearly IHD deaths in West Virginia. The remarkable stability of both CAD prevalence and IHD death rates suggests that similar numbers (i.e., approximately 7,100) have developed and are developing clinical evidence of coronary artery disease each year. These new cases amount to .40 per cent per year of the state's population (7,100/1.8 million).

Indications for Coronary Arteriography

All subjects were referred to the medical center for evaluation of symptoms of chest discomfort, serious arrhythmia, previous myocardial infarction, the development of new chest symptoms, significant combinations of risk factors, or several of the above. The authors felt coronary arteriography was indicated in those patients who displayed significant effort-limiting angina pectoris, angina at rest, or unstable increasing angina pectoris (Table 3). Approximately 25 per cent of new coronary artery disease patients tended to develop one of these forms of angina pectoris as their initial manifestation of the disease. Another 25 per cent of patients whose initial coronary artery disease manifestation was mild, stable angina pectoris or small to moderate myocardial infarction tended to develop more severe levels of angina; they too would then become candidates for study.

Approximately one-third of the patients studied was found not to have coronary disease. These patients were seen because of troubling, disabling chest pain with a diagnosis of probable coronary artery involvement. Coronary arteriographic studies were felt to be indicated in this group primarily to exclude significant coronary disease with its attendant poor prognosis. In addition, some patients undergoing cardiac catheterization to delineate the severity of aortic valve disease, mitral stenosis, or mitral regurgi-

TABLE 1

Coronary Artery Disease Prevalence and Ischemic Heart Disease Deaths in the United States*

1971-1974

Year	*Estimated C.A.D. Prevalence* N	*Deaths From I.H.D.* N	(% total deaths)	*Computed Mean Life With C.A.D.* (years)
1971	3,870,000	675,580	(35.0)	5.73
1972	3,940,000	683,100	(34.9)	5.77
1973	3,990,000	684,066	(34.8)	5.83
1974	4,050,000	664,854	(34.7)	6.09
MEAN	3,962,500	676,900	(34.85)	5.86
STND. DEV.	± 76,350	± 8,869	± 0.13	± 0.16
S.E.M.	± 38,175	± 4,434	± 0.065	± 0.08

*Sources: American Heart Association publication, "Heart Facts"; and National Center for Health Statistics. U.S.P.H.S. - D.H.E.W. publication, "Vital Statistics of the United States."

tation had coronary arteriography; coronary disease was found in 25, 6 and 40 per cent of these groups, respectively.

Coronary Arteriography at WVU Medical Center

Prior to 1973, this laboratory performed fewer than 100 coronary arteriograms per year (Figure). During calendar years '73 and '74, there was a yearly doubling of this case load due, in part, to popularization of the study and to expansion of cardiology staff. During calendar years '75 and '76, there was continued growth by approximately 20 per cent per year. During calendar year '76, more than 400 coronary arteriograms and left ventricular function studies were performed.

Methods of Study

All patients were premedicated prior to coronary arteriography with Diazepam (Valium) 10 mg. and Atropine (0.5 to 1.2 mg., mean dose 1.0 mg.). The right groin was shaved and cleansed; approximately 10 ml. of Lidocaine one per cent (Xylocaine) was introduced into a region surrounding the femoral artery. A two-mm. stab wound was made over the palpable femoral artery impulse and a disposable arteriographic needle was advanced percutaneously into the arterial lumen. A flexible guidewire was inserted into the artery and the needle was withdrawn. Catheters could then be introduced into the artery by way of the intra-arterial guidewire. An 8 Fr. ventriculography catheter was advanced retrograde into the left ventricular chamber. All catheters were flushed with 0.9 per cent saline containing Heparin (500 units per liter).

Left ventriculography was performed prior to the coronary study using Renografin 76 per cent. Injection volume was 40 to 60 ml. (mean volume

TABLE 2

Coronary Artery Disease Prevalence and Ischemic Heart Disease Deaths in West Virginia*

1971-1974

Year	*Estimated C.A.D. Prevalence* N	*Deaths From I.H.D.* N	(% total deaths)	*Computed Mean Life With C.A.D.* (years)
1971	39,500	7,145	(36.3)	5.53
1972	40,300	7,416	(36.0)	5.43
1973	40,700	7,129	(35.7)	5.71
1974	41,400	7,140	(35.2)	5.80
MEAN	40,475	7,207	(35.8)	5.62
STND. DEV.	± 792	± 139	± 0.47	± 0.17
S.E.M.	± 396	± 70	± 0.23	± 0.08

*Sources: American Heart Association publication, "Heart Facts"; and National Center for Health Statistics. U.S.P.H.S. - D.H.E.W. publication, "Vital Statistics of the United States."

TABLE 3

Indications for Coronary Arteriography

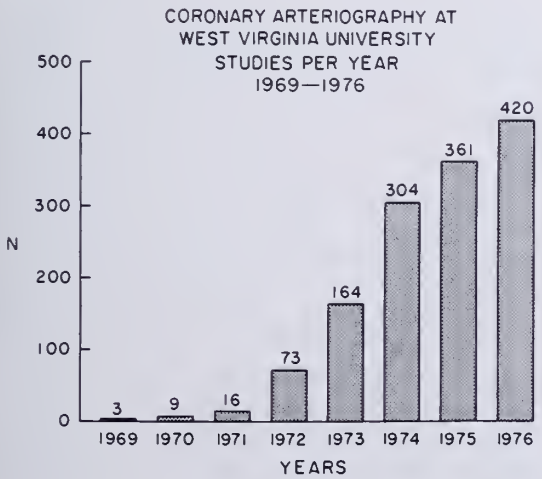
1. Effort limiting (Class III) angina, rest (Class IV) angina, or angina difficult to control medically.
2. Unstable, accelerating angina.
3. Printzmetal's angina.
4. Significant undiagnosed chest symptoms.
5. Aortic valve disease or mitral regurgitation patients undergoing cardiac catheterization.

50 ml.). The injection rate was adjusted to between 8 and 15 ml./sec. The choice of injection volume and rate depended upon the volume of the ventricular cavity and the irritability of the myocardium.

The x-ray anode-to-cathode voltage was adjusted to between 80 and 100 kilovolts and the x-ray pulse width was adjusted to between two and five msec.

Simultaneous video recording (Sony) was made with each and every cine film run. The video recorder provided instant replay of each injection for inspection by the angiographic team between the time of injection and development of the 35 mm. film. This laboratory utilized fine-grain, high-resolution film (Ilford Cinefluer) processed with cinematographic, rather than x-ray, technique (Jameson Processor). During left ventricular angiography the nine-inch mode of the 6/9 image amplifier (Picker) was chosen. For coronary arteriography, the six-inch mode was chosen to insure best resolution of vessels down to approximately 0.2 mm. diameter. The cine camera (Arreflex) was syncronized to open its shutter maximally with each x-ray pulse. The camera accommodated 400-foot film cassettes necessary for coronary arteriography.

If any left ventricular contraction abnormality was visualized during the initial RAO injection



Figure

the patient was rotated to the high left anterior oblique (LAO) position and a second ventricular angiogram was obtained. A five-mm. grid calibration gauge was exposed at the level of the mid-left ventricle in both the right and left anterior oblique positions. This provided x-ray geometric distortion correction during quantitative analysis of the left ventricular angiographic films. Intra left ventricular pressure recordings were made prior to and following each angiogram.

Following the last ventricular angiogram, the catheter was withdrawn to the intrathoracic descending aorta. Under guidewire control, it was removed and a left coronary artery catheter was inserted and advanced to just superior to the ostium of the left main coronary artery. If ostial narrowing was not present, then the catheter was advanced into the left main coronary artery and a series of cine angiograms using manual injection (8 to 10 ml. of Renografin 76 per cent) were made with the patient in the LAO, left lateral, and right anterior oblique (RAO) positions. Several views were obtained to avoid vessel superimposition and to insure visualization of all significant branches. In addition to 60-frame-per-second 35 mm. cineangiography, six-frame-per-second 105 mm. serialography films were obtained. This latter technique provided nearly as good vessel resolution as large cut-film, but with much less radiation and with greater ease of processing. Copies of the best 105 mm. films were enclosed with the complete study report to be sent to the referring physician.

Following left coronary angiography, the catheter was withdrawn into the intrathoracic descending aorta where it was exchanged for a right coronary artery catheter, using the guidewire technique. Right coronary arteriography was performed in the LAO and RAO positions to best reveal its anatomy.

At the conclusion of the study the catheter was withdrawn from the femoral artery and pressure applied to the puncture site for 15 minutes. This achieved hemostasis in all but two cases; in these, the patients had taken oral anticoagulants prior to the study and required approximately 20 to 25 minutes of compression to achieve cessation of bleeding.

Prevalence of Coronary Disease in the Population Studied

Of the 1,300 consecutive coronary arteriograms, 73 per cent (949/1,300) were men and 27 per cent (351/1,300) were women (Table 4). Of the men tested, 66.7 per cent (633/949) were found to have significant coronary artery

disease (i.e., 70 per cent stenosis or occlusion of one or more vessels), while only 36.8 per cent (129/351) of the women were found to have significant disease (P.<.001). Differences in the prevalence of coronary artery disease between men and women occurred in all age ranges between 30 and 60. Only 12 patients over the age of 70 and 20 patients under the age of 30 were studied.

In the age group of 20 to 29, four patients (three men, one woman) were found to have significant CAD. All males had juvenile onset diabetes. The woman, 21, showed complete occlusion of the right coronary artery and 80 per cent stenosis of both the anterior descending and circumflex vessels. She suffered from both hyperlipidemia (Type II) and juvenile onset diabetes.

The prevalence of coronary artery disease for both sexes increased with each decade group from ages 30 to 59; however, no significant difference in prevalence could be found from ages 60 to 70 for either sex.

Coronary Artery Disease Combinations

The frequency of specific combinations of coronary artery disease are shown in Table 5. The most frequently found combination was three-vessel disease involving stenosis and/or occlusion of left anterior descending (LAD), left circumflex (LCX), and right coronary artery (RCA): 25 per cent (191/762) of the patients studied showed this combination. The combinations in descending order of frequency were found to be LAD + RCA, LAD alone, LCX + RCA, RCA alone, left main coronary artery disease (LMCA), LAD + LCX, and finally LCX alone. This latter amounted to only 5.4 per cent (41/762) in our patient group.

Single-vessel disease was present in 31.9 per cent (243/762), and two-vessel disease was found in 34.2 per cent (261/762). The LAD was found to be diseased in 66.7 per cent of patients, RCA in 62 per cent, LCX in approximately 47 per cent, and LMCA in approximately 8.8 per cent.

Left Ventricular Function

Left ventricular wall motion abnormalities demonstrated by left ventricular angiography consisted of segmental or global reduction of wall motion (hypokinesis), absence of wall motion (akinesis), or abnormal bulging of the wall in systole (dyskinesis). Three-vessel disease demonstrated the greatest frequency of abnormal wall motion: 53 per cent (102/191) of the patients with this combination showed wall motion abnormalities (Table 5). In descending order of frequency, the single-vessel diseases producing wall motion abnormality were LAD (34 per cent), RCA (31.8 per cent) and LCX (13.3 per cent). A randomized study of 110 of our subjects with single-vessel coronary artery disease (Table 6) demonstrated that while angina pectoris tended

TABLE 4

Age and Sex Distribution of Coronary Artery Disease in 1,300 Consecutive Coronary Arteriograms at West Virginia University Medical Center (1971-1976)

Age Group	Men: Total N	Men: Coronary Disease N	Men: Coronary Disease (%)	Women: Total N	Women: Coronary Disease N	Women: Coronary Disease (%)	$P(x^2)$ Between Sexes	Both Sexes: Total N	Both Sexes: Coronary Disease N	Both Sexes: Coronary Disease (%)	$P(x^2)$ Between Age Groups
20-29	16	3	(18.73)	4	1	(25.00)	N.S.	20	4	(20.00)	
											.100
30-39	110	47	(42.73)	36	3	(8.33)	.001	146	50	(34.25)	
											.005
40-49	286	186	(65.03)	113	30	(26.55)	.001	399	216	(54.14)	
											.005
50-59	384	285	(74.22)	137	65	(74.45)	.001	521	350	(67.18)	
											.500
60-69	144	104	(72.22)	58	28	(48.28)	.001	202	132	(65.35)	
											.100
70-79	9	8	(88.89)	3	2	(66.67)	N.S.	12	10	(83.33)	
All Ages	949	633	(66.70)	351	129	(36.75)	.001	1300	762	(38.62)	

Notation: P = Probability of equal coronary disease distribution between sexes, N.S. = Insufficient sample size.

TABLE 5

Coronary Artery Disease Combinations in 762 Subjects with Abnormal Coronary Arteriograms

Diseased Vessel(s) Groups	N	% Total	*P (binomial) Between Groups*	*Abnormal LV Wall Motion* N	*Abnormal LV Wall Motion* % Group	*P(x²) Between Groups*
LAD, LCX, and RCA	191	(25.07)		102	(53.4)	
			.001			.250
LAD and RCA	138	(18.11)		66	(47.5)	
			.638			.025
LAD	131	(17.19)		45	(34.0)	
			.001			.025
LCX and RCA	75	(9.84)		39	(51.8)	
			.726			.025
RCA	71	(9.32)		23	(31.8)	
			.711			.250
LMCA	67	(8.79)		23	(34.6)	
			.064			.250
LAD and LCX	48	(6.30)	.010	21	(44.0)	
			.441			.005
LCX	41	(5.38)		5	(13.3)	
TOTALS	762	(100.00)		322	(42.3)	

to develop with greater frequency beyond 70 per cent stenosis, left ventricular dysfunction tended to develop when the stenosis became greater than 95 per cent.

In summary (Tables 5 and 6), left ventricular dysfunction was more apparent when (1) greater numbers of coronary arteries were diseased; (2) coronary stenosis was greater than 95 per cent; and (3) LAD or RCA was involved rather than LCX. Left circumflex disease demonstrated the least tendency to develop left ventricular dysfunction.

Complications of Coronary Arteriography

Table 7 lists the complications occurring in 1,300 consecutive coronary arteriograms performed at the West Virginia University Medical Center during the years 1971 through 1976 inclusive. These are listed both as numbers and percentages of total cases. In addition, comparison with the mean complication rates from other institutions performing more than 100 studies per year cited by Adams *et al*[4] are shown. This laboratory sustained one death in a series of 1,300 percutaneous coronary arteriograms. (.077 per cent). This occurred in a 63-year-old male Caucasian who suffered accelerating angina pectoris over the preceding two months. Rest angina had been present for several days prior to and during the study. The proximal left main coronary artery showed 95 per cent stenosis, and extensive severe stenosis was present at all major branches of the coronary tree. Immediately following the second coronary artery injection, the patient developed chest pain, profound hypotension, and three mm. ST-segment elevation. Resuscitation measures were started immediately but the patient failed to respond. Autopsy revealed a "pin-hole" lumen of the proximal left main coronary artery and extensive stenosis of not only the left, but also the right, coronary system.

As a result of that death, the authors initiated the procedure of performing a manual injection of 10 ml. contrast material immediately superior to the left coronary ostium. This layer of contrast was found to descend into the left ostium during diastole, disclosing the presence or absence of significant stenosis. Visualization of the left main coronary ostium without entrance of the catheter tip in the opening avoided the risk of chance occlusion. Since the above technique was adopted, we have been without mortality in over 1,100 cases. Included were 32 additional patients with left main coronary disease and three with left main ostial stenosis.

Myocardial infarction following arteriography developed in one patient (.077 per cent). This

TABLE 6

The Relationship of the Severity of Coronary Artery Stenosis to Angina Pectoris and Left Ventricular (L.V.) Dysfunction in Subjects with Single-Vessel Coronary Disease (N = 110)

Coronary Stenosis (%)	N	*Angina Pectoris* N	(%)	*P(X²) Between Groups*	*L.V. Dysfunction* N	(%)	*P(X²) Between Groups*
30-49	8	1	(12.5)	> .25	0	(0)	> .25
50-69	8	2	(25.0)	< .025	0	(0)	
70-79	7	6	(85.7)		2	(28.6)	
80-89	15	11	(73.3)	> .25	1	(6.7)	< .001
90-95	30	25	(83.3)		4	(13.3)	
96-100	42	36	(85.7)		24	(57.1)	
TOTAL	110	81	(73.6)		31	(28.2)	

43-year-old male Caucasian suffered crescendo angina beginning three weeks prior to the study. Angiography revealed a 99 per cent stenosis of the proximal anterior descending branch. Although the study was uneventful, 12 hours after the procedure he experienced severe and persistent anterior chest pain with ST-segment elevation and later Q-wave development over the anterior precordial leads. Although the myocardial infarction may not have been directly related to the coronary study, we are including it in our list of complications because it occurred within 24 hours of the procedure.

TABLE 7

Complications from 1,300 Consecutive Coronary Arteriograms Performed at West Virginia University Medical Center 1971-1976

Complications	N	WVU Med. Center (N=1300) (%)	Average at Institutions Performing over 100 Studies Per Year (N=16,281)* (%)
Death	1	0.077	0.56
Myocardial Infarction	1	0.077	0.22
Ventricular Fibrillation	2	0.154	1.00
Cerebral Emboli	0	0	0.35
Femoral Thrombosis	2	0.154	0.86
Severe Reaction to Contrast Agent	0	0	0.037
TOTALS	6	0.462	3.027 (P < .005)

*Adams *et al* (1973).

Transient ventricular tachyarrhythmia occurred in two cases (.154 per cent). Both were terminated within 30 seconds of their onset, one spontaneously and the other with direct current countershock. In both instances, the study was continued uneventfully and was not related to occlusion of a vessel. Cerebral emboli have not occurred in our series. Femoral thrombosis occurred in two patients (.154 per cent) These were manifested as a cool right foot with diminished pulses and diminished doppler flow at and distal to the level of the femoral artery puncture site. In both instances clots were found at the puncture site and were removed by surgical thrombectomy. The patient suffered no further sequelae following removal of the clot. No patients had significant contrast dye reaction, although four showed one or two skin wheals. This was treated with antihistamine without sequelae.

Institutions performing over 100 studies per year (N=16, 281) reported by Adams *et al*[4] showed greater complication rate than this institution (P<.005). In part, this may reflect the inexperience of many investigators in performing the percutaneous coronary arteriography. We anticipate other institutions will demonstrate reduced complications as their experience with the method increases. As familiarity with the method increases the elapsed time for performing the study should diminish, thereby reducing the

length of time the catheter remains in the vicinity of the coronary ostia. This, in turn, should reduce the chance of catheter tip thrombus inadvertently injected into the coronary tree. A time motion analysis of 100 consecutive coronary and left ventricular function studies performed by one of us (AFB) demonstrated a mode elapsed time for coronary arteriography studies of seven minutes, with a range from four to 12 minutes and an average of just over nine minutes. The mode elapsed time for left ventricular angiography was 10 minutes, with a mean of 12.6 minutes.

Conclusion

Coronary arteriography performed by a team of experienced physicians and technicians is a rapid, safe procedure providing an unexcelled view of coronary anatomy and pathology. The percutaneous femoral approach can be done with little hazard, minimal discomfort, and excellent patient and physician acceptance. When the study can be performed with little risk it needn't be reserved for only those cases for whom surgery is contemplated, but can be applied to any patient with troubling, undiagnosed chest complaints. The utility of the negative coronary angiogram should not be minimized. The authors have had no complications in patients with normal coronary arteriograms. The harmful effects of morbid concern over the possible presence of heart disease and over-treatment of nonexisting coronary disease can be avoided.

The clinical care of the patient with coronary disease can be improved by knowing which prognostic category he represents. The patients with isolated circumflex disease or distal right disease can be reassured and the emphasis placed upon risk factor reduction and prevention of further plaque formation. The patients with more extensive coronary disease can be evaluated for the possibility of revascularization. Treatment of patients with severe left ventricular dysfunction can be targeted toward the avoidance of congestive failure, arrhythmia, or embolic problems.

TABLE 8

Elapsed Time Analysis for 100 Consecutive Coronary and Left Ventricular Function Studies (AFB)

	Mode Elapsed Time (min.)	Median Elapsed Time (min.)	Mean Elapsed Time (min.)	Standard Deviation (min.)
Coronary Arteriography	7.0	8.9	9.60	±3.83
Left Ventricular Angiography	10.0	11.5	12.56	±2.87
Total Times	18.0	20.5	22.16	±6.70

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Appendicitis Due To Strangulation In A Femoral Hernia: Report Of A Case

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A rare case of a strangulated appendix in a femoral hernial sac resulting in an acute inflammation of the appendix is presented. The isolation of the appendix outside of the peritoneal cavity causes the usual signs of peritoneal inflammation to be absent in these cases until actual necrosis causes leakage of purulent material into the peritoneal cavity.

THE appendix is rarely found in a femoral hernia sac, and even more rare is an acute inflammation of the appendix within a femoral hernia sac. The table from the article by Wise and Tanner[1] gives an idea of the rarity of the finding of the appendix in a femoral hernia sac. In 1731, a case of a femoral hernia containing a suppurative appendix was reported by De-Garengot.[2] It is also interesting that the first successful appendectomy in 1736 was performed through a right inguinal hernia sac by Amyard.[3] Between 1731 and 1968, there were 240 cases of femoral hernia containing the appendix reported in the medical literature[4] and, since 1968, only a few isolated cases have been reported. Even more rare is the presence of an inflammation of the incarcerated appendiz. Voitk, MacFarlane and Estrada of McGill University, in their review of the English medical literature in 1972, found only 59 cases of acute appendicitis in a femoral hernia recorded, and they added two of their own cases.[5] Gerami, Easley and Mendoza reported, in 1970 from the Clarksburg, West Virginia, Veterans Administration Hospital, the case of an appendiceal abscess due to a gangrenous appendix in a right femoral hernia.[6]

Case Report

A 56-year-old unemployed male Caucasian had a right direct inguinal hernia repaired in 1967. He came to the Surgical Clinic of the Clarksburg VA Hospital on January 13, 1977, stating that his "hernia had recurred." One year before, he had noted a tender nodule in the same area, but it had disappeared in a few days. The nodule recurred one week before coming to the hospital and was quite tender. He had tried to push it back in, but was unsuccessful.

On physical examination, his temperature was 97.8 degrees F. orally; the pulse was 80 per minute; respirations, 20 per minute; and blood pressure, 160/86. All of the examination was normal except for a tender, firm nodule 3.5 x 3.5 x 2 cm. under the medial third of the previous right inguinal herniorrhaphy scar. The protrusion could not be reduced. The abdomen was soft, flat, and non-tender.

The CBC, urinalysis, and SMA 6/60 were all within normal limits. The white blood cell count was 5,200/mm^3 with 56 per cent neutrophils, 34 per cent lymphocytes, and 10 per cent eosinophils. The chest x-ray was normal.

On January 17, 1977, under endotracheal general anesthesia, the scar of the previous right inguinal herniorrhaphy was excised. Upon dissection of the firm nodule, it was found to be a femoral hernial sac which turned upward over the inguinal ligament. It was of black color from old bloody fluid within the sac. The sac was opened and a specimen was taken of the bloody fluid for smear and culture. The bloody fluid was due to a strangulated piece of omentum which was dark and hemorrhagic. Lying alongside the strangulated omentum was

TABLE

Incidence of Cases of Appendix Contained in Femoral Hernia Sac*

Author	No. of Femoral Hernias	No. of Femoral Hernias With Appendix in Hernia Sac
Frankau (1931)	680	4
Shawan and Altman (1935)	97	3
Gault and Baylis (1936)	230	2
Wakeley (1938)	610	3
McClure and Fallis (1939)	90	2
Koontz (1952)	139	2
Rose (1954)	30	1
Rogers (1959)	170	1

*Table modified from Wise and Tanner.[1]
Table also appeared in article by Voitk, Macfarlane, and Estrada.[5]

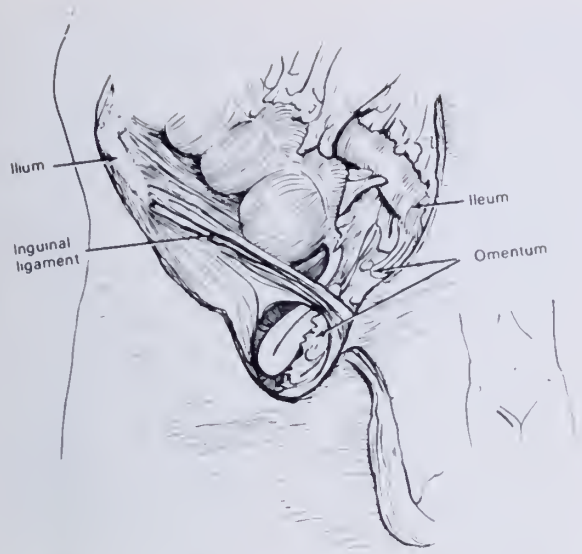

Figure 1. Drawing of strangulated appendix and omentum in the right femoral hernia.

the appendix doubled back upon itself in "U" fashion and also firmly wedged into the neck of the sac (Figure 1). Upon finding this situation, another, higher, oblique muscle-splitting incision was made to enter the peritoneal cavity. By this approach, the neck of the femoral hernial sac was opened. The strangulated omentum was extracted and amputated. The appendix was then slipped out easily from the sac and a routine appendectomy was performed. The hernial sac was ligated from within the abdomen and, via the lower incision, Prolene 0 sutures were used to close the femoral canal by uniting the inguinal ligament to the pectineal ligament of Cooper.

The patient had an uneventful postoperative course. He was given intravenous cephapirin (Cefadyl) for two days and then oral cephalexin (Keflex) for three more days. He developed no fever and the wound healed well. The cultures of the bloody fluid did not yield any bacterial growth. The patient was discharged on January 20, 1977, to be followed in the Surgical Clinic.

The pathology report on the omentum was "infarcted omentum" showing hemorrhage, thrombi in arterioles, and polymorphonuclear infiltration. The report on the appendix was "acute appendicitis and chronic periappendicitis" with inflammatory infiltrate from mucosa to serosa (Figures 2 and 3). This was thought due to strangulation of the appendix.

Comments

Compression by the constriction of the neck of a hernial sac is an uncommon but demonstrable cause of appendicitis. In the case reported here, the portion of the appendix distal to the constriction at the neck of the hernial sac was inflamed and infiltrated by leukocytes, while the proximal portion of the appendix was normal. The usual case of appendicitis is caused by intraluminal obstruction, whereas this case was caused by an extraluminal compression.

Preoperative prediction of the appendix as a content of a femoral hernial sac is extremely difficult. In our case, even a preoperative diagnosis of a femoral hernia was not made

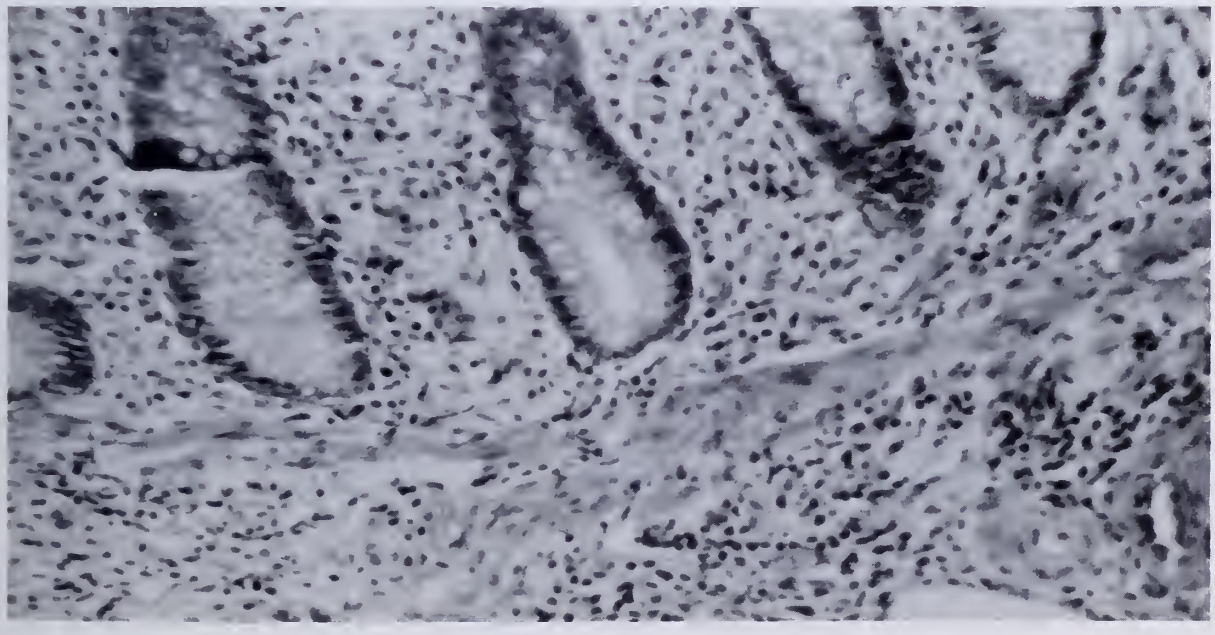

Figure 2. Inflammatory infiltrate in portion of mucosa, submucosa, and inner muscularis. L.P. - 10X.

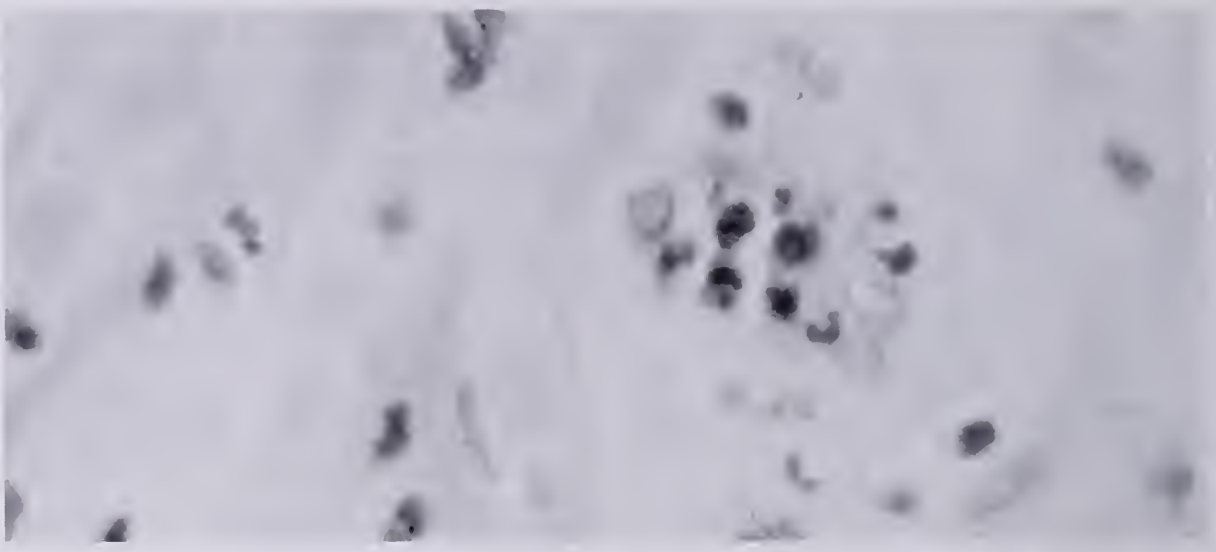

Figure 3. Polymorphonuclear infiltrates in muscularis of appendix. H.P. - 40X.

because of the position of the presenting mass well above the inguinal ligament underlying the scar of the previous inguinal herniorrhaphy, and because no hernial impulse was found. The usual symptoms and signs of peritoneal inflammation are not present in the cases of acute strangulated appendicitis in a femoral hernia because the appendix is isolated outside of the peritoneal cavity by the constricting ring of the femoral canal. The inguinal ligament above, the pectineal ligament of Cooper below, the lacunar ligament medially, and the femoral vessels laterally, provide a firm, unyielding ring about the strangulated contents of the femoral hernia. In our case also, no gastrointestinal symptoms were present. There was no lower abdominal tenderness, no fever, and no leukocytosis, and there seemed to be no urgency to perform the surgery. These factors tend to deceive both the patient and his physician as to the potential danger of necrosis of the appendiceal wall with eventual intra-peritoneal leakage of purulent material. Our patient waited seven days before coming to the hospital and then was four days in the hospital before having surgery.

Summary

A rare case of strangulated appendicitis in a femoral hernial sac is presented and the difficulty of making a correct preoperative diagnosis is explained.

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Acute Monocytic Leukemia On Stage IV Neuroblastoma Following Radiation And Cyclophosphamide Therapy

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The diagnosis of Stage IV Neuroblastoma was made on this 58-year-old white male in November, 1970. He received local radiation therapy and a combination of vincristine and cyclophosphamide therapy. He died of acute monocytic leukemia in January, 1975, some 50 months after onset of treatment. There was no evidence of neuroblastoma at autopsy. The quintad of neoplasia-(radiation-radiomimetic drug)-mutagenesis-oncogenesis-neoplasia syndrome is entertained in this case.

Case Report

Mr. H. B., a 58-year-old white male, who had a long history of obesity, mild hypertension, and a hiatus hernia repaired twice, was well until November, 1970, when he developed epistaxis. A polyp was removed from the left nare. The diagnosis of neuroblastoma was made (Figure); also, there was invasion into the ethmoid area. He was treated with 6,000 rads cobalt therapy.

In May, 1971, he complained of left chest pain of radicular nature. X-rays showed demineralization and narrowing of the bodies of T9, 10 and 11. In July, 1971, x-rays of the left mandible showed an osteolytic process with pathologic fracture, and x-ray of the thoracic spine showed loss of the pedicle on the left of T5. He was given 2,000 rads radiation therapy to the T5 region and left mandible. There was no evidence of other involvement, but he did have marked proptosis of the left eye and, in September, 1971, received 3,300 rads cobalt therapy to the left orbit. Parenteral cyclophosphamide and vincristine were administered and continued until November, 1971, at which time he was placed on oral cyclophosphamide, with vincristine given to the limits of fingertip numbness. His blood counts remained stable and he was free of significant illness. The dose of cyclophosphamide varied according to his total white blood cell count. He worked daily and maintained a good attitude and frame of mind and was always cheerful. He was seen every few weeks. During much of 1974 he ran a persistent, unexplained leukopenia; therefore, cyclophosphamide was stopped in August, 1974. He had problems with upper respiratory infections during that year.

A bone marrow was performed in October, 1974, in an effort to explain his leukopenia. The

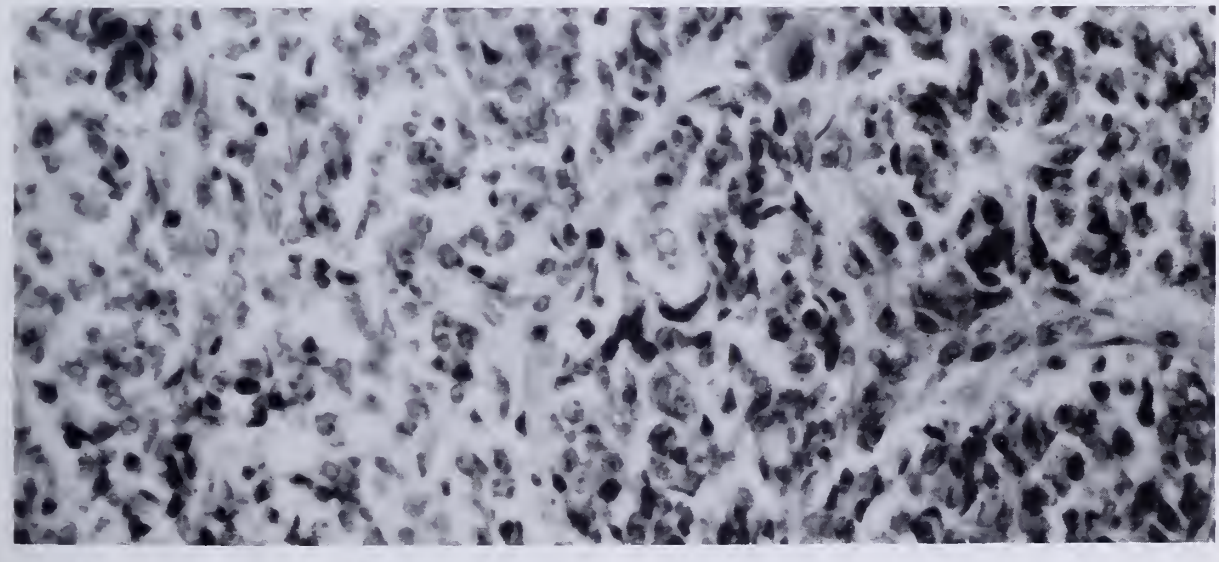

Figure. Sections of the tissue from the left nasal cavity and specifically from the ethmoid area show a highly malignant olfactory neuroblastoma composed of small, dark cells arranged in irregular groups surrounded by connective tissue strands. The nuclei showed considerable variation in size, and mitotic figures are numerous. Many fragments of tissue show nasal mucosa with mucous glands. Also, there are some bone fragments. Other sections show nasal mucosal tissue and nasal wall tissue invaded by olfactory neuroblastoma. Tissue photographed at 43X magnification.

marrow was hypoplastic, but there were a number of unidentified cells of the moncytoid and myelocytoid types. He was given a course of bleomycin therapy at that time. In November of 1974, anemia was noted and he was transfused. The peripheral smear showed seven per cent monoblasts. He was treated with prednisone, anabolic steroids, and bleomycin was continued. He was hospitalized again in December, 1974, because of a perirectal abscess, and at that time his peripheral smear showed 45 per cent monocytes and monoblasts. His platelet count was 25,000. He was transfused and given platelet transfusions plus antibiotic therapy.

He was readmitted later in December with recurrent perirectal abscess. The white blood cell count was 5,600, with 32 per cent monoblasts, and his platelet count was 15,000 per cubic millimeter. Transfusions were given as well as parenteral antibiotic therapy; anti-leukemia therapy was initiated, using cytosine arabinoside. The white blood cell count fell progressively to 1630, with 20 per cent monoblasts, but his infection was difficult to control. His general condition deteriorated to a comatose state and he expired on January 2, 1975.

A post mortem examination showed acute monocytic leukemia with hemorrhage into brain, lungs, kidney, and prostate. He had a duodenal diverticulum, pulmonary congestion, and chronic passive congestion of the liver and spleen.

He had received cyclophosphamide to August 12, 1974, and this was stopped because of recurrences of bacterial upper respiratory infections, persistent leukopenia, and an abnormal peripheral blood smear. There was no evidence of neuroblastoma at post mortem examination. Instead, the evidence indicated that his basic disease was cured and that he died of the complications of acute monocytic leukemia—probably secondary to cyclophosphamide therapy.

Discussion

The metabolites of cyclophosphamide in blood serum of the experimental animal and man have (1) cytostatic, (2) immunosuppresive, (3) alkylating, (4) cytogenetic, (5) teratogenic, and (6) carcinogenic, activities.[6,7,8] This activity results mainly from an enzymatic process of liver microzomes in the presence of oxygen and $NADPH_2$ which activates cyclophosphamide to the "Wirkform."[9,10]

Khaleeli *et al*[11] presented four patients with sideroblastic anemia. These cases occurred from a total of 55 patients with multiple myeloma observed over a 10-year period. Treatment was comprised of daily low-dose melphalan. All of these patients developed myelomonocytic leukemia within six months after sideroblastic anemia had been noted. Also reviewed were 18 patients with multiple myeloma trated with cyclophosphamide or melphalan since 1970 who died of acute myelomonoblastic leukemia.

Five cases of sideroblastic anemia in patients with myeloma had been reported in 1971.[12] Allen *et al* presented a patient with acute myelomonocytic leukemia, monoclonal macroglobulinemia, Bence Jones proteinuria and hypercalcemia. Concurrent multiple myeloma or Waldenstrom's macroglobulinemia could not be completely excluded. The possibility of that constellation of findings suggested a synthetic activity of the acute leukemia myeloblast.[13] Van Hove *et al*[14] reported two patients with myeloma of 12 and eight years' duration prior to the onset of leukemia.

Holt *et al*[15] reported four patients treated successfully for myeloma. Two received cyclophosphamide and two, melphalan. Three patients went on to develop a highly malignant sarcoma and the fourth, who was treated with melphalan, developed myeloblastic leukemia, with chromosomal examination of bone marrow cells showing abnormal karyotypes. There was no evidence of relapse of myeloma. They discussed three possibilities: (1) such developments reflect nothing more than the natural history of myeloma as it is altered with longer survival by chemotherapy; (2) complicating malignancies may be a direct consequence of nuclear damage due to chemotherapeutic agents; and (3) the host immue response already interfered with because of defective production of normal immune globulins is further impaired due to lymphocytic suppression. They thought it was wrong to imply that chemotherapy was harmful, because, no doubt, the quality of life was improved and overall survival was significantly lengthened. It would seem that the development of alternative malignancy following successful chemotherapy does occur.

Acute erythroid leukemia on multiple myeloma following cyclophosphamide was reported by West[16] in patients receiving cyclophosphamide and melphalan, and spot radiation of 98 and 71 months after the date of the original diagnosis of myeloma. On autopsy, there was no evidence of myeloma, and the diagnosis of erythroid leukemia was noted, plus other tumors, to wit, squamous cell carcinoma and anaplastic carcinoma of the urinary bladder.

Multiple myeloma on polycythemia vera following radioactive phosphorus therapy also was reported by West.[17] This occurred some three years after the diagnosis of polycythemia vera was made.

The course of the subject of our case report is similar to those described here and in the bibliography. He had an excellent response (and remission of his neuroblastoma) to local radiation therapy and a combination of cyclophosphamide and vincristine. He died of acute monocytic leukemia without autopsy evidence of neuroblastoma; however, he had good guality of life for over four years and was productive and worked a significant part of each day.

The early diagnosis of this mutagenic syndrome is characterized by bone marrow changes. persistent leukopenia without radiation therapy or chemotherapy, thrombocytopenia, and abnormal peripheral white cells, either monoblast, myeloblast, myelomonoblast, or erythroblast. These neoplasias are difficult to treat and the physician should be wary of the patient with malignant disease on long-term chemotherapy who develops persistent pancytopenia with decreased or no radiation or chemotherapy.

It is evident from the medical literature that when this develops there may be no evidence of the primary tumor on post mortem examination. It is also apparent that the second neoplasia is more difficult to treat than the initial tumor.

From this experience plus numerous others, one supposes that the alternative malignancies were indeed due to cyclophosphamide therapy, but this should not mitigate its use in malignant disease as the advantages far outweigh the disadvantages. Caution, of course, should be used if this agent is to be employed in the treatment of non-malignant disease for the purpose of immunosuppression.

Neoplasia of this nature is no doubt due to mutagenesis from long-term alkylation therapy. It should be the responsibility of physicians nowadays to design chemotherapeutic protocols that would spare the immune mechanism as much as possible and perhaps enhance the immune mechanism in several ways. It is reasonable to think that combination chemotherapy used in a cyclic fashion is superior to maintenance chemotherapy for a great majority of patients with malignant disease. Time would permit the immune mechanism to "bounce back," and it is reasonable to use immune-stimulating agents such as influenza vaccine and BCG prior to each course or every other course of intermittent, combined chemotherapy.

Summary

This 58-year-old white male was treated for Stage IV neuroblastoma from November, 1970, until his death in January, 1975, covering a period of 50 months. He received local radiation therapy and a combination of vincristine and cyclophosphamide during most of this time. He died of acute monocytic leukemia without autopsy evidence of neuroblastoma. This case is presented primarily to reinforce the fact that radiation therapy and radiomimetic agents are indeed mutagenic and oncogenic and are capable of producing alternate neoplasia. However, the quality of life is improved with these forms of therapy. Efforts should be made to design treatment protocols which protect and possibly even enhance a person's basic immune mechanism while giving chemotherapy or radiation therapy—and yet accomplish treatment goals.

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Manuscript Information

Manuscripts to be presented for publication in *The West Virginia Medical Journal* should be typewritten, triple-spaced, on one side only of firm (no onion skin or flimsy), standard letter sized (8 1/2 by 11 in.) white paper. Wide margins (at least 1 1/4 in. on left) should be left free of typing. On the first or title page should be shown the title of the article, the name (or names) of the author, and his degrees. Pages should be numbered consecutively, the page number being shown in the right upper corner along with the surname of the author.

Where reference is made to generically-designated drugs, the first such reference must be followed by parentheses containing the most commonly known trade-name drug of that designation. In addition, a listing of all generic drugs mentioned in the article, with their trade-name equivalents, should appear at the end of the article.

A short abstract summarizing the manuscript should be included. This should be typed in double space on a separate page.

Authors are requested to submit a carbon copy with the original.

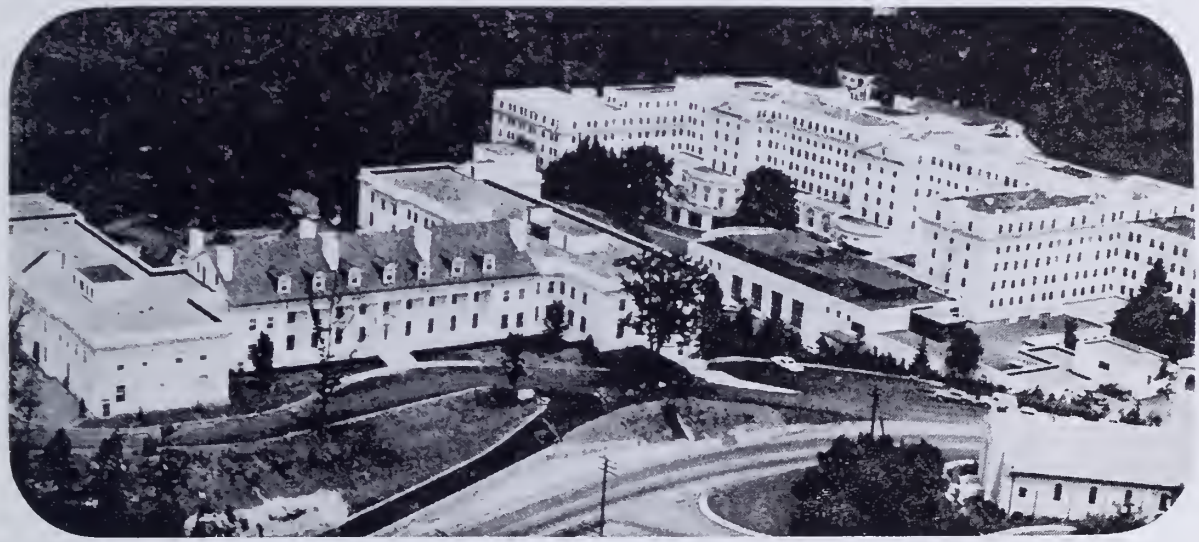
Illustrations should be numbered and their approximate locations shown in the text. Each should be identified by placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for reproduction should be done in black (India) ink on pure white. Photographs should be on glossy paper and minimum of about 5 by 7 in. in size. A legend should be provided for each illustration and, preferably, attached to it.

All scientific material appearing in *The Journal* is reviewed by the Editorial Board. Manuscripts should be mailed to The Editor, West Virginia Medical Journal, Box 1031, Charleston, W. Va. 25324.

111th ANNUAL MEETING

of the

West Virginia State Medical Association



The Greenbrier

AUGUST 23-26, 1978

PLAN NOW TO ATTEND

A message from . . .

The President

KNOW CANDIDATES IN PRIMARY

FEBRUARY 4, about the time this issue of *The Journal* reaches your desk, will be the deadline for filing candidacies for nomination to legislative and other offices in the May primary election.

In other words, you'll then know who is running for what—and there probably is no time in this state's history when a thorough knowledge of candidates, including their backgrounds, their philosophies and their records if they are seeking renomination, has been more important.

It's also true that, in many instances, the real races of significance will be those in the primary. Because of partisan characteristics identifying many areas, specifically heavy voter registration featuring one party or the other, general election races in November can be academic.

Without sounding like a broken record, it's important for the Medical Association leadership to again remind all physicians that the direction which health and medical care will take in the future is one of the major issues of the day. At stake is the availability of quality care for all Americans. Cost effectiveness, not cost containment, is the challenge with which all Americans properly must be concerned.

Get to know your candidates, particularly those seeking nomination and election to West Virginia's State Senate and House of Delegates. Encourage your patients to get to know them, too—and for what those candidates stand. For it's the patient, and the public in general, who represent the so-called "bottom line."

Joseph A. Smith, M.D.

JOSEPH A. SMITH, M. D., *President*

The West Virginia Medical Journal

Editorials

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author shall be held entirely responsible.

HEALTH CARE COMPETITION

It has been adequately demonstrated that market supply and demand principles do not apply in the health care industry. This is so because of the limitless or insatiable demands for health care services.

Recent concerns about encouraging competition in the provision of medical care seem to be directed at providing some competitive edge for an HMO type of operation. From the fiscal standpoint this clearly makes sense. If such a system were universal, care costs could be budgeted and would be much more predictable than they are now. In the framework of the present system of primarily employer-paid health care insurance benefits, the consumer has little stake in seeking out economies in health care.

In a truly competitive situation it is quite likely that given two neighbors, one with an HMO arrangement and the other with hospitalization and outpatient medical care coverage, and both with an inguinal hernia, it is possible that the neighbor with the HMO coverage will be fitted with a truss and the one with private hospitalization and outpatient coverage will be brought quickly to surgery. In the light of present day public enlightenment and sophistication about medical matters and a certain glamour associated with going to surgery, it is possible that the neighbor walking about with his truss will feel somehow undertreated. The HMO would thus appear at some disadvantage in spite of the fact that either treatment would probably meet acceptable standards. If both neighbors were covered by the same HMO package there would be no problem.

The example given is perhaps a poor one and perhaps even presents an HMO in an unfavorable light. It is not the purpose of the example to accomplish that. The example should illustrate, however, that in order to keep within fixed budgets an HMO must effect economy where possible. Such economies might not be in keeping with a consumer's preconception of what good medical care might be or what care, in his experience, a neighbor is getting. If both had some percentage financial interest in the costs, for instance, by a mandated percentage co-payment, the neighbor with the truss might feel a little bit happier walking along cutting his lawn behind a new power mower he purchased with money saved by avoiding hospitalization.

Some rationing agent is clearly needed to hold down medical care costs effectively. The most logical person to provide this rationing function is the patient himself. He must be motivated to do this by incentives stronger than sharing with every other taxpayer in the country the tax savings attributable to his sacrifice.

A layered regulatory approach, the only apparent alternative to rationing in the control of medical care costs, will inevitably be as self-defeating as the regulatory approach to welfare costs. Who is to protect the public from the regulators? Such a question is not frivolous.

WHO'S CRYING WASTE?

Officials of our fiscally potbellied federal government feel perfectly free to call the kettle black.

HEW Secretary Joseph Califano told the annual meeting of the American Medical Association last June that "reasonable cost has not been the strong suit of either American medicine or most of its physicians."

But as suggested by an AMA delegate from the state of Washington, the wording could well be changed to: "Reasonable cost has not been the strong suit of either *American government* or its *politicians*."

In Secretary Califano's own bailiwick, how was economic rationality served by HEW's having to spend a reported $750,000 to re-do its incredibly botched-up list of high Medicare payees?

There are plenty of other vivid examples of the federal government's ineligibility to preach economizing—to physicians or anyone else. Here are a few:

*Sen. William Proxmire (D.-Wis.) has deplored the "fleecing" of taxpayers for such undertakings as an $84,000 study to determine why people fall in love; a $27,000 analysis of why prison inmates want to escape (not *how*, mind you, but *why*); a $46,000 inquiry into how long it takes to cook breakfast (including the boiling time for three-minute eggs?); and not less than $3,400,000 for a Madison Avenue advertising campaign to stimulate letter-writing, plus $775,000 to test the campaign results. Assuming that Americans were suddenly stirred to become better pen pals, how well would the extra hills of mail be delivered?

*Sen. Barry Goldwater (R.-Ariz.), in his recent book, *The Coming Breakpoint*, cites such "bureaucratic projects" as a $20,000-a-year study of German cockroaches (aren't American good enough?); a $70,000 analysis of the smell of Australian aborigine sweat; and a university-compiled dictionary of witchcraft, by courtesy of a $46,089 federal grant.

Rising medical and hospital costs are a problem we must face and are facing—through commissions and other formal initiatives within our AMA federation. But government "solutions" to the problem would be like using mosquitoes to fight yellow fever. The public should be told.—*Guest editorial by American Medical Association.*

IF THE DECISION WERE BY THE SICK

The increase in cost of medical care is consistent with increase in cost of most other major parts of our economy—food, gasoline, and housing, etc. But physicians know that this is not the real issue. The fact is, the cost of medical care should not be addressed the same as other costs. There are some things that cannot be measured in dollars—as we learned at our mother's knee.

Take the hallmark of the present debate on cost containment, the CT Scanner. What is the cost of two or three days' wait, or longer, for examination by one of the limited numbers? It is not only the hospital per diem! It is not only the occasional cost in life where immediate examination could have been lifesaving! An immeasurable cost of delay is the worry and agonizing of the patient until the diagnosis is made.

Every patient wants the best. But this fact is not the prime concern of the health planner who makes his decision by numbers and statistics.... Perhaps the decisions on cost of medical care should be made only by those who have been seriously ill...—*Rocky Mountain Medical Journal*, September-October, 1977.

Our Readers Speak

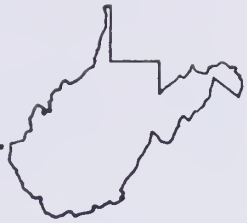
Faults Editorial Quote

As an expatriate British physician who has been made more than welcome in the United States, I cannot but register a complaint concerning your editorial, "The Kind of System We Do Not Need" (November, 1977). This quotes the "first-hand" impressions of the British National Health Service as seen through the eyes of the Richmond physician. This peripatetic, closed mind is an appallingly biased observer, since he is wrong more often than chance alone allows him to be. Let me start with the spelling mistakes: it is Doctor Cumming, not Cummin; it is Aneurin, not Aneuryn Bevan. Next, "Doctor Cumming" can hardly be called upon as an architect of the NHS; he was at school in 1942, and I do not believe either Lord Beveridge or Mr. Bevan used school boy consultants. The Corn Laws were not enacted in 1836, and moreover have nothing to do with the provision of clothing, food and shelter either to vagrants or to the poor. In practice, they were laws which imposed tariffs on imported foreign grain, and were responsible for most of the working class being unable to buy bread in the early 19th century. Lloyd George was not Britain's Prime Minister in 1911—it was Asquith. The legislation that was passed in that year did not put the poor and destitute on free medical care; rather, it introduced the concept of pre-paid health insurance to Britain. It is possible for me to go on ad nauseam . . .

There is much that is wrong with the British National Health Service (NHS), but very little that cannot be corrected by a big infusion of money and the sacking of a goodly number of the administrative bureaucrats. True, under the NHS there are people who wait a year to have their varicose veins tied or their hernia repaired, but our Richmond observer would do well to remember that many persons in North America have various organs removed before disease has developed. To talk of a breakdown in the health care in Britain is abject rubbish, and to give credence to this sort of bias and distortion does you and your readers a disservice. There are many cogent reasons for arguing against the adoption of a replica of the British National Health Service in America without resorting to such gross inaccuracies . . .

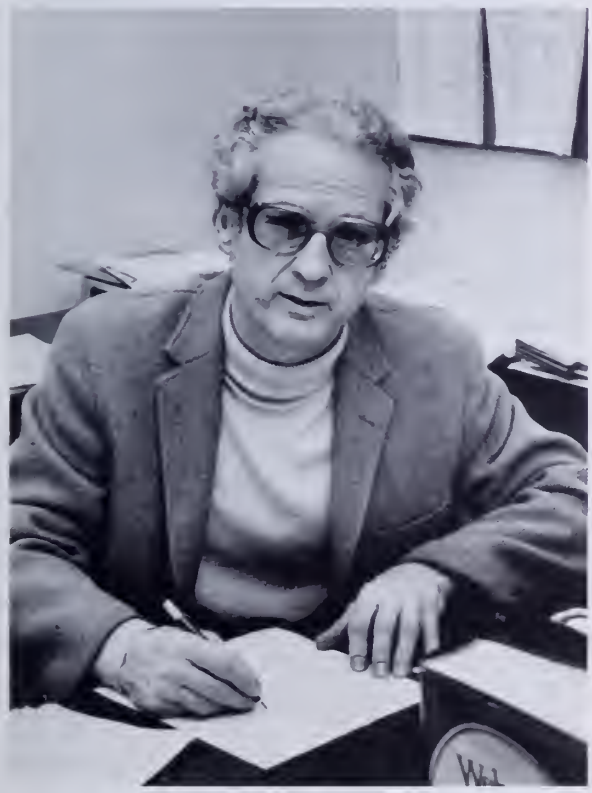
W. Keith C. Morgan, M. D.
Professor of Medicine
West Virginia University School of Medicine, Morgantown

GENERAL NEWS



Editor Of Medical Economics Annual Meeting Keynoter

James A. Reynolds, Executive Editor of the widely read *Medical Economics* and a journalist known to many West Virginia physicians, will deliver the 9 A.M. Thursday, August 24, keynote address during the West Virginia State Medical Association's 111th Annual Meeting at the Greenbrier in White Sulphur Springs.



James A. Reynolds

The address again will be in honor of the late Dr. Thomas L. Harris, Parkersburg surgeon, civic leader and former President of the Medical Association.

Mr. Reynolds joined *Medical Economics* in 1963, serving first as Managing Editor and later as Washington Editor. Earlier, he worked for the *National Geographic* and *The Wall Street Journal*, as well as for United Press.

He did his undergraduate work at Oklahoma A&M (now Oklahoma State University), then received a master's degree in journalism at Syracuse University.

Mr. Reynolds' presentation will offer another change of pace in the Annual Meeting's keynote address, with his topic to be fashioned according to activity then current in the general spheres of medical legislation and economics.

Annual Meeting activities will get under way with a 2 P. M. meeting of the Association's Executive Committee on Tuesday, August 22; the usual pre-Convention meeting of the Council at 10 A. M. on Wednesday, and the opening session of the House of Delegates at 2:30 P. M. on Wednesday.

An invitation has been extended to Dr. Tom E. Nesbitt of Nashville, Tennessee, who will be installed as President of the American Medical Association in St. Louis in June, to address the August 23 House session.

The opening exercises, featuring Mr. Reynolds' address, will be followed on Thursday morning by the Convention's first general scientific session, a "Symposium on New Developments in Treatment of Common Disorders."

The second general session on Friday morning, August 25, will offer papers on high-risk pregnancy, surgical management of obesity and West Virginia's new Medical Examiners' System.

The AMA's Department of Practice Management will be in charge of the Saturday morning general program, with presentations covering personnel necessary to assure efficiency in physicians' offices; and patient relationships (communications, information, rapport).

More specific information relative to general session topics and speakers will be provided in upcoming issues of *The Medical Journal*. Meanwhile, reservation forms provided by the Greenbrier were included with a year-end bulletin to all Association members mailed in late December, 1977, and those planning to attend the Annual Meeting are encouraged to give them their earliest possible attention.

The general Convention format once again will provide opportunities for breakfast, luncheon and other meetings, of a scientific and/or business nature, of the various sections and specialty organizations affiliated with the Medical Association. It is anticipated that the bulk of these again will be scheduled on Friday, August 25.

Plans also call for the usual President's Reception on Wednesday evening, August 23, and the Saturday evening reception for new officers. The latter will follow the second and final House of Delegates session at 2:30 P. M. on Saturday which will bring the inauguration of Dr. Robert D. Hess of Clarksburg as President to succeed Dr. Joseph A. Smith of Dunbar.

The Annual Meeting of the Auxiliary to the State Medical Association, with Mrs. Joseph T. Mallamo of Fairmont in charge as the Auxiliary's President, again will run concurrently with the Association's Convention.

Special Convocation Celebrates MU Medical School Opening

A special convocation was held in Huntington on January 10 to celebrate the opening of the Marshall University School of Medicine. Both Governor John D. Rockefeller IV and former Governor Arch A. Moore, Jr. were platform guests.

The convocation was held in the new Huntington Civic Center. Marshall President Robert B. Hayes termed the event a "landmark" in Marshall's history. About 2,500 persons attended the ceremony.

Governor Rockefeller delivered greetings and former Governor Moore was recognized for his role in the establishment of the medical school. Both men hold honorary degrees from Marshall.

Max Cleland, head of the federal Veterans Administration, was the featured speaker. The medical school was established in cooperation with the Veterans Administration and much of its funding in its early years is being provided by the VA.

Mr. Cleland, a veteran and triple amputee, said that President Carter's upcoming budget message would contain some good news for West Virginians in general and the medical school in particular. He added that the VA was prepared to spend about $16 million on faculty and facilities for the medical school during the next seven years.

The convocation also included the awarding of honorary degrees to U. S. Senator Jennings Randolph, Dr. Albert C. Esposito, Huntington

Max Cleland (right), Administrator, Veterans Affairs, U. S. Veterans Administration, was the principal speaker at the special convocation held in the Huntington Civic Center on January 10 to celebrate the opening of the Marshall University School of Medicine. He is shown chatting with Marshall President Robert B. Hayes.

physician and a leading advocate of a Marshall medical school over the past 25 years, and James H. (Buck) Harless, southern West Virginia business leader and former Chairman of the Appalachian Regional Hospitals chain, with which the medical school is affiliated.

The event included a formal academic procession by the Marshall faculty. The medical school's first class, made up of 24 men and women, was introduced by Dean Robert W. Coon.

Platform guests included Dr. Charles A. Hoffman of Huntington, Past President of the American Medical Association, and Congressman Nick Joe Rahall.

The 24 students began their studies January 3. They are scheduled to graduate in the spring of 1981. Thirteen West Virginia communities and one in Kentucky are represented in the first class. Four women are members of the class. Sixteen students hold undergraduate degrees from West Virginia schools. Twelve institutions of higher education, including the U. S. Military Academy at West Point, are represented.

The students are:

Francis S. Hunter, Sandra Jean Joseph, Douglas C. McCorkle, Stephen F. Morris, Stephen T. Pyles, Stephen C. Smith, John F. Toney, and Robert E. Turner, all of Huntington; Galen E.

Castle of Ashland, Kentucky; Mikell Ann Crews, James W. Matthews and Steven D. McCarus, all of Charleston;

Patrick C. Bonasso, Fairmont; Emmett F. Branigan and Keith H. Wharton, both of Morgantown; Dennis M. Burton, Williamstown; Harry G. Camper III, Welch; Brian P. Fawcett, Wheeling; Durwood F. Gandee, Weirton; Cecil D. Groves, Summersville; Leslie N. Heddleston, Princeton; Brenda C. Smith, Dunbar; Nina Kay Smith, Ripley, and Richard A. Yocum, Moundsville.

State AAFP Scientific Assembly In April

The 26th annual Scientific Assembly of the West Virginia Chapter, American Academy of Family Physicians, will be held April 7-9 in Charleston at the Holiday Inn Charleston House.

Sessions will begin at 8:45 A. M. Friday, April 7, and continue through noon on Sunday. Dr. Marshall J. Carper of South Charleston, President, West Virginia Chapter, AAFP, will preside at the opening session.

Asel P. Hatfield, M.D.

Some 17 scientific topics and speakers, to be announced in the March issue of *The Journal*, will be included in the program this year.

Meetings of the Board of Directors will be held on Thursday, April 6, at 7 P. M., and Sunday at 1 P. M.

The House of Delegates will meet on Friday from 12 Noon to 1:30 P. M., and the annual banquet will be held Saturday evening.

To Install Doctor Hatfield

Dr. Asel P. Hatfield of Harrisville, President Elect, is program chairman for the 1978 meeting, during which he will be installed as President.

He has been in family practice in Harrisville since 1953, and team physician for Harrisville High School for 23 years. He has been Coroner (now Medical Examiner) for Ritchie County since 1957.

Doctor Hatfield was a member of the Board of Directors of the West Virginia AFP from 1970 to 1975, and has been Chairman of the Academy's Membership and Credentials Committee since 1972.

A native of Goffs, in Ritchie County, Doctor Hatfield was graduated from Harrisville High School and attended Marshall University. He was graduated from the former two-year West Virginia University School of Medicine, and

For the first time under the West Virginia State Medical Association's five-year-old professional liability insurance program sponsored with Aetna Life & Casualty, the state's physicians have been receiving dividends amounting to 2 per cent of premiums collected by Aetna in the 1976 account year. Pictured with a symbolic check totaling $84,398, representing the total amount of the dividend realized from administrative expenses related to the program, are (left to right) Dr. Lyle D. Vincent of Parkersburg, Chairman of the Association's Committee on Insurance; Dr. John J. Mahood of Bluefield, Chairman of the Council; Dr. Joseph A. Smith, Dunbar, Association President, and Mr. Tom Auman, Aetna's Account Supervisor for the Association-sponsored program.

Dr. David H. Williams (left) of Weirton, is shown at a recent meeting of the State Medical Association's Council with Dr. Stephen D. Ward of Wheeling, Association Vice President. Doctor Williams was elected to the Council during the Association's Annual Meeting last August.

Dr. William Y. Rial (center) of Swarthmore, Pennsylvania, new Speaker of the American Medical Association's House of Delegates, chats with West Virginia's Delegates, Drs. Frank J. Holroyd (left) of Princeton and Richard E. Flood of Weirton, prior to a House session during the AMA's interim business meeting in Chicago in early December. Doctor Rial was presiding over the House for the first time since his election in June to succeed Dr. Tom E. Nesbitt of Nashville, Tennessee, now the AMA's President Elect. Doctor Rial had been the House's Vice Speaker before being named to his new office.

received his M. D. degree in 1952 from the Medical College of Virginia. He interned at McKeesport (Pennsylvania) General Hospital.

Doctor Hatfield is a Charter Fellow of the American Academy of Family Physicians. He is a member of the Parkersburg Academy of Medicine and the State Medical Association, serving on the Association's Nurses Liaison Committee.

February 'State VD Awareness Month,' Group Urges

February is being observed as "State VD Awareness Month" by the Committee for Venereal Disease Education of the West Virginia University Medical Center.

The committee, composed of medical, pharmacy and nursing students, notes that, "in West Virginia, nearly one-third of the infectious cases reported are at the junior-senior high age level, exceeding the national average by 15 per cent."

The committee stated that VD is the nation's number one communicable disease problem, adding that health professionals in West Virginia are urged to "assist in raising the public's awareness of the seriousness of the current VD epidemic in our state."

While curing gonorrhea and syphilis is not difficult, the committee observed, "identifying the infected who are unknowingly disease carriers and referring them to medical care does present a major roadblock to disease management. However, without the public's recognition of the problem and its conscientious assistance, control is not possible."

Continuing Education Activities

Here are the continuing medical education activities listed primarily by the West Virginia University School of Medicine for part of 1978, as compiled by Dr. Robert L. Smith, Assistant Dean for Continuing Education. The schedule is presented as a convenience for physicians in planning their continuing education program. (Other national, state and district medical meetings are listed in the *Medical Meetings* Department of *The Journal.*)

The program is tentative and subject to change. It should be noted that weekly conferences also are held on the Charleston and Wheeling campuses as well as in Morgantown. Further information about these may be obtained from: Division of Continuing Education, WVU Medical Center, P. O. Box 2867, Charleston 25330; Office of Continuing Medical Education, WVU Medical Center, Morgantown 26506; or, Office of Continuing Medical Education, Wheeling Division, WVU School of Medicine, Ohio Valley Medical Center, 2000 Eoff Street, Wheeling 26003.

Feb. 20-24	Morgantown	Family Practice Review Course
Mar. 11	Morgantown	Annual Conjoint Behavioral Medicine—Internal Medicine Day
Mar. 17, 18	Morgantown	Cancer Teaching Days—Pediatric Oncology
Mar. 24	Charleston	Fifth Annual Newborn Day
Mar. 25	Wheeling	Seminar on Surgical Problems
Apr. 7	Charleston	Behavioral Medicine and Psychiatry Conference
Apr. 8	Parkersburg	Cardiology Teaching Days
Apr. 24	Morgantown	Fourth Annual ENT Teaching Day

Doctor Flood President of State Medical Boards Federation

Dr. Richard E. Flood of Weirton will be installed as the 64th President of the Federation of State Medical Boards of the U.S., Inc., at its Annual Federation Dinner on February 4 at the Palmer House in Chicago. The dinner is held in conjunction with the annual Congress on Medical Education of the American Medical Association.

Doctor Flood has been a practicing family physician and surgeon in Weirton for 30 years. A 1933 graduate of Catholic Central High School in Steubenville, Ohio, where he was captain of the football team, Doctor Flood attended the University of Notre Dame, receiving a B. S. degree in biology in 1937. He received his M. D. degree in 1941 from Jefferson Medical College in Philadelphia. His internship training was at Harper Hospital in Detroit, and he was a surgical associate of Dr. Clark D. Brooks of Detroit in 1942.

Doctor Flood is a Clinical Professor in the Department of Family Practice at West Virginia University School of Medicine, where he lectures one or two days a month.

During World War II, Doctor Flood served for 42 months in both the European and Pacific Theatres of operations and was discharged a major in 1946, when he began private practice.

He is a Past President of West Virginia Academy of Family Physicians and is a member of the National Joint Practice Commission between Medicine and Nursing, formed by the American Medical Association and the American Nursing Association.

He has served as Secretary and President of the Hancock County Medical Society. He was a member of the Council of the West Virginia State Medical Association and was elected President of the Association in 1966-67, the centennial year of the Association.

In 1968, Doctor Flood was elected as an Alternate Delegate to the American Medical Association, and has served as one of the two West Virginia Delegates to the AMA since 1969. Other responsibilities with the AMA include membership on the Committee on Nursing and as a member of the AMA Committee on Membership Opinion Polls.

Doctor Flood is a Past President of the Century Club of the College of Steubenville and has served on that college's advisory board. He also is a member of the Advisory Board for Nursing at West Virginia Northern Community College, and is Past President of Fort Steuben Academy of Medicine. He is currrently Chairman of Weirton General Hospital's Pharmacy and Therapeutic Committee and Utilization Review Committee.

Doctor Flood was appointed to serve as a member of the Medical Licensing Board of West Virginia in 1969 and is still a board member. At the 1974 Annual Meeting of the Federation of State Medical Boards, he was elected to serve as a member of the Board of Directors, and was elected Vice-President in 1976.

Statement On 'Bonding' Concept Approved By AMA

Support for the immediate "bonding" of mothers with their newborn infants was given a major boost last December when the American Medical Association adopted a Statement on Parent and Newborn Interaction urging enhancement and humanizing of the birth experience.

"Bonding" is the concept of giving newborn infants to their mothers immediately after birth, allowing the two several moments or more to make skin-to-skin and eye contact. If fathers are present, they too join in the bonding or "attachment" process.

Bonding is then further promoted by allowing the mother or both parents extensive time with the newborn child during the days immediately following birth.

The 249-member House of Delegates, the policy-making body of the AMA, adopted the statement on the importance of bonding prepared by the Committee on Maternal and Child Care of the AMA Council on Scientific Affairs and the Committee's recommendation that hospital medical staffs review hospital practices covering delivery "and, if necessary, develop and formulate new guidelines respecting all aspects of professional support for the birth and nurturing process."

The Committee report did make clear that changes in delivery practices should be instituted in keeping with hospital standards for good medical care. While stating that "Innovative alternative settings for birth in the hospital with adequate professional support should be explored and evaluated," the report noted that "Reevaluation of existing practices must preserve the significant technological advances which have resulted in improved obstetrical and newborn care."

Howard G. McQuarrie, M. D., Salt Lake City obstetrician and Chairman of the Committee on Maternal and Child Care which worked for some

four years on the bonding philosophy statement, was jubilant about the House action.

"We are delighted that not only our own Committee and the Council on Scientific Affairs, but now the House of Delegates, recognizes the importance of this concept," Doctor McQuarrie said. "This action by the AMA will now allow medical staffs in hospitals across the country to address the matter of humanizing the delivering or nurturing event."

The House action is a vital step, Doctor McQuarrie added, in combating the surge of home deliveries in recent years "which some scientific studies indicate lead to fetal risk six times that in hospital deliveries."

While deploring this "unacceptable" risk to the infant born at home, Doctor McQuarrie said some expectant parents feel driven to non-hospital deliveries "in trying to achieve the family-oriented birth experience."

With AMA support, he said, "hospitals can now examine their positions and work toward enhancing and sustaining this important nurturing event."

In its formal report and recommendations, completed after four years of research, study and preparation, the Committee on Maternal and Child Care referred to the work of Pierre Constant Budin, the turn-of-the-century French obstetrician and author of the first known text on neonatology (the diagnosis and treatment of disorders of the newborn infant).

A specialist in the care of premature infants, Doctor Budin also invented the human incubator, which he designed with a glass window so parents could watch and help care for their ill babies.

In his text, *The Nursling*, published in 1907, Doctor Budin wrote of the devastating effect separation of mothers from their infants at birth had on the mothering process. Noted Doctor Budin, "Mothers separated from their young soon lost all interest in those whom they were unable to nurse or cherish."

MEDICAL WRITING

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Medical Meetings

Feb. 3-5—74th Congress on Medical Education, Chicago.

Feb. 8-12—American College of Psychiatrists, New Orleans.

Feb. 13-16—The Management of Obesity (Dept. of Psychiatry, Johns Hopkins U. School of Med.), Baltimore.

Feb. 19-20—Southeastern Surgical Congress, New Orleans.

Feb. 22-26—Am. Assn. of Genito-Urinary Surgeons, Key Largo, Fla.

Feb. 22-26—Am. College of Nuclear Physicians, San Francisco.

Feb. 23-28—Am. Academy of Orthopaedic Surgeons, Dallas.

March 2-4—International Congress on Colonoscopy and Diseases of Large Bowel, Miami Beach.

March 6-9—Am. College of Cardiology, Anaheim, Calif.

March 10-15—Am. Society of Abdominal Surgeons, Las Vegas.

March 13-16—ACS, Cincinnati.

March 29—April 1—Am. Fertility Society, New Orleans.

April 5-6—W. Va. Chapter, Am. Academy of Pediatrics, Wheeling.

April 7-9—W. Va. Chapter, AAFP, Charleston.

April 24-29—Am. Academy of Neurology, Los Angeles.

April 26-29—W. Va. Academy of Ophthal. & Otolaryn., White Sulphur Springs.

May 3-6—W. Va. Chapter, ACS, White Sulphur Springs.

May 4-7—ASIM, San Francisco.

May 10-12—Med. & Chirurgical Faculty of the State of Md., Hunt Valley, Md.

June 10—W. Va. State Society of Anesthesiologists, Morgantown.

June 11-13—Am. Diabetes Assn., Boston.

June 17-22—AMA Annual Meeting, St. Louis.

Aug. 23-26—111th Annual Meeting, W. Va. State Medical Assn., White Sulphur Springs.

Sept. 25-28—AAFP, San Francisco.

Nov. 11-14—Southern Medical Assn., Atlanta.

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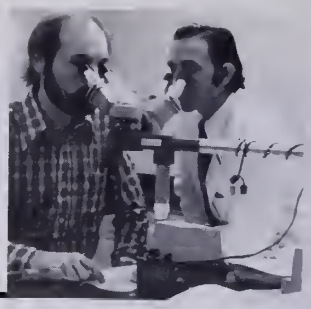

Compiled from material furnished by Mrs. Mary Ellin Wylie, Director, Medical Center News and Information Services, Morgantown, W. Va.

'Probably Preventable' Infant Deaths Key In Study

West Virginia's poor infant mortality rating could be improved to better than the national average if "probably preventable" deaths were eliminated, according to a WVU study.

It indicates that one in four or five infant deaths could be prevented by more comprehensive health care. In 1975, the last year for which full figures are available, that would have amounted to 109 of the 505 deaths.

The Study was conducted by WVU medical student Roger Lewis of Terra Alta, Preston County, under a grant by the March of Dimes to the Department of Community Medicine.

One of its purposes was to indicate what portion of infant deaths are caused by less than ideal care delivery, as opposed to general socioeconomic factors like low income and little education.

Lewis was able to match death certificates with birth certificates for 480 of the 505 infant deaths recorded during 1975, out of some 28,000 live births in West Virginia.

Of the 109 deaths listed as "probably preventable," 29 were caused by problems with delivery which the study found might have been prevented by referral to a center for handling high-risk pregnancies.

Ten might have been prevented if delivery had been monitored and the newborn had received excellent care, and 16 others if the mother had been better educated about infant care. Respiratory Distress Syndrome caused 38 probably preventable deaths; congenital heart disease, 9, and miscellaneous reasons, the other 7.

Classified as probably preventable were deaths of infants who weighed more than 1,500 grams and lived more than 24 hours but weren't transferred to a referral center, those with complications resulting from birth or with abnormalities that can be corrected, and high-risk pregnancies not referred for management to a specialized care center.

Referral Gap From Rural Clinics Target Of Federal Grant

The federal government has allocated $600,000 to WVU researchers to come up with a better way to get rural clinic patients to urban specialty care—and thus extend the range of services available to such patients.

Rural clinics have helped spread the benefits of modern medical care to isolated sections of the state in recent years, according to Project Director Charles D. Holland, but a gap remains in the referral system for getting specialized care for those with more serious medical problems.

A recent study of four new clinics indicated that about half of the patients referred to specialists had no reports of that care in their clinic records. More than a third of the patients didn't return to their primary care clinic following referral.

Holland is Unit Coordinator of the Office of Health Services Research in the Department of Community Medicine. He noted that consultation or referral to another physician "can present problems under the best conditions."

"It's quite clear that less than ideal conditions are the rule in rural clinic settings. Services are naturally limited, some clinics are isolated geographically and many don't have regular working relationships with specialists and hospitals.

"It's mainly a communications problem: does the second physician get the needed records? Does he confer with the referring doctor? What kind of continuing relationship do they have? Does the record of the specialist's treatment get back to the referring physician? Does the patient himself return?"

Federal money for the project, amounting to $200,000 for each of three years, comes from the Health Underserved Rural Areas (HURA) program of the Department of Health, Education and Welfare.

The initial $200,000 will be spent during the coming year to examine existing referral patterns, demonstrate alternative ways to handle the problem and set up the first of two referral networks. The second demonstration project will operate during the second and third years.

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Third-Party News, Views and Program Concerns

Education Factor Discovered In Hypertension Levels

Analysis of blood pressure levels measured by the Hypertension Detection and Follow-up Program (HDFP) on 158,906 adults in 14 United States communities confirms that the greater the number of school years completed, the lower the prevalence of high blood pressure. The education factor is more apparent in younger age groups and in blacks, but it was found in all race and sex groups and at all the age groups (30-69) included in this population under study.

An extremely important finding from the HDFP data is that the difference in education could only partially account for racial differences in prevalence of hypertension. Education as a single index of social and economic status does not fully reflect the differences in life that may contribute to the differential.

The HDF Program was initiated by the National Heart, Lung, and Blood Institute (NHLBI) in 1971 to determine the effectiveness of systematic and sustained antihypertensive therapy in reducing the number of deaths associated with high blood pressure in the general population of these 14 communities. In the United States, about 23 million persons have high blood pressure.

Apart from race, the reasons for the higher rates of hypertension in the less educated are not yet clear. The education "effect" may operate through factors such as dietary or other behavioral differences (e.g., higher salt intake or being overweight). Being overweight, which is consistently associated with hypertension, is more common in the least educated.

Although the inverse relationship between blood pressure and education had been noted in earlier studies, these studies did not permit the examination of this relationship in a large biracial population where age and weight could be considered, and where significant numbers of both blacks and whites at various levels of educational attainment could be included.

The hypertensive individuals were defined as those with a diastolic pressure of 95 millimeters of mercury or higher and those whose diastolic pressure was under 95 who were currently taking antihypertensive drugs. About 23 per cent of the total study population was found to be hypertensive, and about twice as many blacks as whites (37.4 per cent vs. 18.0 per cent).

Hypertension was found to be 40 per cent less prevalent in college graduates than in those with less than 10 years of schooling. This difference is considerably stronger in blacks, especially under age 50. Among the youngest blacks (30-39), college graduates have hypertension prevalence rates almost 50 per cent lower than those with less than 10 years of formal schooling (13.7 per cent vs. 26.6 per cent).

These early findings appear in the November, 1977, *American Journal of Epidemiology*, under the title, "Race, Education and Prevalence of Hypertension."

A report has been prepared by the HDFP Cooperative Group and is supported by the NHLBI through contracts to 17 cooperating centers. They are:

Atlanta, Georgia: Emory University; Baltimore, Maryland: University of Maryland; Birmingham, Alabama: University of Alabama; Boston, Massachusetts: Trustees of Health and Hospitals, Boston; Chicago, Illinois: Northwestern University;

Davis, California: University of California; East Lansing, Michigan: Michigan State University; Evans County, Georgia: Evans County Heart Department; Georgetown (Washington), D. C.: Georgetown University; Jackson, Mississippi: University of Mississippi; Los Angeles, California: Cedars-Sinai Medical Center;

Minneapolis, Minnesota: Mount Sinai Hospital and University of Minnesota; New York, New York: Albert Einstein College of Medicine; Salt Lake City, Utah: University of Utah; Coordinating Center, Houston, Texas: University of Texas; Central Laboratory, Chicago, Illinois: Northwestern Memorial Hospital, and ECG Center, Minneapolis, Minnesota: University of Minnesota.

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E.E.N.T.
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D. G. Anderson, Business Manager
H. L. Castilow, Asst. Business Monager

Obituaries

CHARLES M. WARD, M. D.

Dr. Charles M. (Bud) Ward of Eccles (Raleigh County), died on December 22 in a Beckley hospital. He was 62.

A native of Beckley, Doctor Ward was a retired physician and real estate agent. He was graduated from West Virginia Wesleyan College and received his M. D. degree in 1942 from the University of Maryland School of Medicine.

Doctor Ward was a former member of the Raleigh County Medical Society, West Virginia State Medical Association and the American Medical Association.

Survivors include two sisters, Mrs. Helen Leeber of Beckley and Mrs. Janice Greene of Seattle, Washington.

* * *

ROBERT D. KETCHUM, M. D.

Dr. Robert D. Ketchum of Charleston died on December 8 in a hospital there. He was 74.

A native of Marietta, Ohio, Doctor Ketchum was graduated from West Virginia University and received his M. D. degree in 1930 from Jefferson Medical College of Philadelphia. He interned at Charleston General Hospital.

He was a member of the Kanawha Medical Society, the West Virginia State Medical Association and the American Medical Association.

Survivors include the widow; three daughters, Mrs. Marilyn Stone of St. Petersburg, Florida; Mrs. Jane Pelletier of Jeffersonville, Indiana, and Miss Cornelia Ketchum of Barboursville; a son, Robert D. Ketchum, Jr., of Louisiana, and a sister, Mrs. John T. Collins of Lewisburg.

* * *

WILLIAM C. COOK, JR.

Dr. William C. Cook. Jr., Charleston surgeon, died on January 14 in a hospital there. He was 60.

A native of Welch, Doctor Cook was Director of Medical and Hospital Services of the State Department of Welfare.

He was a member of the Board of Directors of the Hygiene Facilities Foundation, a member of the American Board of Abdominal Surgeons, a Fellow of the American College of Surgeons, and a member of the American Association of Abdominal Surgeons.

Doctor Cook was graduated from Ohio State University and received his M. D. degree in 1943

Continued on page xvi

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Final classification of the less-than-effective indications requires further investigation.

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County Societies

MONONGALIA

The Monongalia County Medical Society met on December 6 at the Old Mill Club in Morgantown.

Dr. James L. (Jack) Frost of Morgantown, Medical Examiner for North Central West Virginia, spoke about the organization of the medical examiner system in his area.

The Society voted to go on record as being opposed to the selection of the golf course as the site for the new West Virginia University stadium because of its close proximity to two hospitals, making access to the hospitals difficult.—H. Summers Harrison, M. D., Acting Secretary.

OBITUARIES (continued from page xiv)

from the University of Virginia Medical School. He began his practice in Charleston in 1950 after serving his internship at the University of Virginia and his surgical residency at McGuire Veterans Administration Hospital in Richmond, Virginia.

A veteran of World War II, he also was a member of the Kanawha Medical Society, the West Virginia State Medical Association and the American Medical Association.

Survivors include the widow; a daughter, Miss Judith Cook of Charleston; three sons, William C. Cook, III, George S. Cook and Charles R. Cook, all of Charleston, and a sister, Miss Eunice Cook of Milton.

Program On Rationing Medical Care Planned By ASIM

Leaders in business, labor, government and medicine will suggest priorities for the rationing of medical care at the American Society of Internal Medicine's 1978 Annual Meeting May 4-7 at the Hyatt Regency in San Francisco.

"Medical Care, Ltd." is the theme for the meeting's program, which will examine rationing of care, the effectiveness of the government's alphabet programs (PSROs, HSAs, HMOs and IPAs), new drug legislation, stress and holistic medicine. Eight hours of category 1 continuing medical education credit are offered.

Representatives of 51 state societies of internal medicine will also convene in ASIM's House of Delegates to establish Society policy on such issues as cost containment, national health insurance, health planning and quality assurance.

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B. G. Thimmappa, M. D.
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The Nervous System, by W. F. Ganong, M. D. 226 pages. Price $8. Lange Medical Publications, Los Altos, California 94022. 1977.

Current Surgical Diagnosis and Treatment, 3rd Edition, by J. Engelbert Dunphy, M. D.; Lawrence W. Way, M. D., and associate authors. 1139 pages. Price $18. Lange Medical Publications, Los Altos, California 94022. 1977.

Handbook of Pediatrics, 12th Edition, by Henry K. Silver, M. D.; C. Henry Kempe, M. D., and Henry B. Bruyn, M. D. 723 pages. Price $9. Lange Medical Publications, Los Altos, California 94022. 1977.

The New Way to Live With Diabetes (paperback), by Brian Boylan and Charles Weller, M. D. 140 pages. Price $2.50. Doubleday & Company, Inc., 245 Park Avenue, New York, New York 10017. 1966 (revised 1976).

Clinical Cardiology, by Maurice Sokolow, M. D.; and Malcolm B. McIlroy, M. D. 659 pages. Price $16. Lange Medical Publications. Los Altos, California 94022. 1977.

Current Medical Diagnosis & Treatment, by Marcus A. Krupp, M. D.; Milton J. Chatton. M. D.; and associate authors. 1,098 pages. Price $17. Lange Medical Publications, Los Altos, California 94022. 1978.

AMA Names Executive

Susan T. Carver, M. D., formerly of Cornell University Medical College, New York City, has been named to the American Medical Association's medical education group.

Doctor Carver is a graduate of Columbia University College of Physicians and Surgeons, and has been affiliated with Cornell University Medical College since 1960. She also served as Associate Attending Physician and Associate Director for Professional Services of the New York Hospital.

Dr. Carver will serve the AMA as Assistant Director of the Department of Undergraduate Evaluation in the organization's medical education unit. Her husband is Dr. J. Robert Buchanan, President of Michael Reese Hospital in Chicago.

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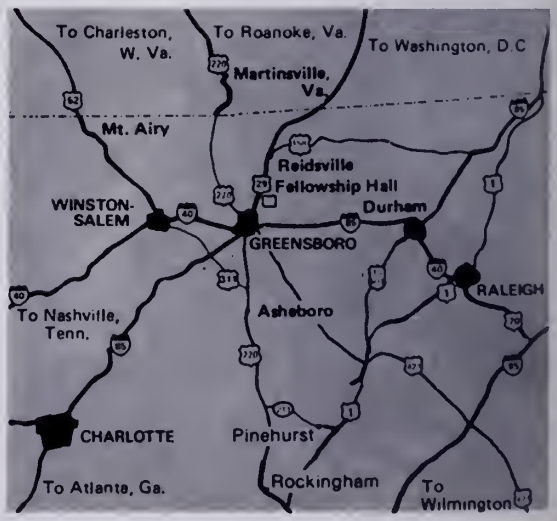

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The West Virginia Medical Journal

Vol. 74, No. 3 March, 1978

Laparoscopic Sterilizaton: Experience With The Falope-Ring™

ROBERT P. PULLIAM, M. D.
120 Professional Park, Beckley, West Virginia.

Falope-Ring™ sterilization is a safe, effective means of female sterilization. The technique is easily learned and eliminates the complications of electrical burns and reduces complications due to bleeding. To avoid luteal phase pregnancies the procedure should be performed immediately postmenstrual in all patients except those on oral contraceptives. Postoperative pain is not a significant problem when general anesthesia is used. This article documents the use of this technique by a six-member obstetrical and gynecological group.

Laparoscopic sterilization has become the most commonly performed gynecological surgical procedure in many hospitals today. Although infrequent, complications of the procedure may be serious, and can be divided into the broad general categories of physioperitoneum. electrical, bleeding, penetration, infections, and pregnancy. Bleeding and infection complications are common to all surgeries, while the remaining ones are specifically limited to, but not necessarily inherent in, laparoscopic sterilization. The insistence upon proper patient selection, optimal equipment, conditions, training, and experience will reduce most complications to a minimum. Electrical burns (2.2/1000), particularly to the bowel, and to a greater extent, bleeding complications (6.4/1000), are the most feared and are almost exclusively technique related.[1] If it were possible to occlude the tubes without the use of electric current, these rare but devastating complications could be virtually eliminated.

The development of the Falope-Ring™ and appropriate applicators offers to the laparoscopist such a technique. Developed at Johns Hopkins University Hospital by Yoon, King, and others,[2] the basic laparoscopic procedure, either single or double puncture, is exactly as classically described except that it allows tubal occlusion without the use of electric current, thus eliminating electrical complications and greatly reducing those due to bleeding.

Materials

The Falope-Ring™ applicator* is composed of three elements: the mobile inner tongs or grasping forceps, a hollow non-mobile central cylinder, and the movable outer cylinder or barrel. Bi-directional motion of both tongs and outer cylinder is controlled by a single, sliding thumb-holder mechanism.

The Falope-Ring,™** or silastic band, is made of silicone rubber with an inner diameter of one mm., outer diameter of 3.6 mm., and a thickness of 2.2 mm. When the ring is stretched using a cone-shaped loading device and applied over the central cylinder, the inner diameter is 5.5 mm. Excellent permanent memory (100 per cent) is maintained if not stretched above six mm. and if the device is applied promptly.

Because of their size, the single-puncture applicator and the double-puncture applicators both require special trocars and sleeves. All other equipment is the same as that used for other laparoscopic procedures.

Method

The series consisted of 639 cases performed at the Raleigh General Hospital, a private, for-profit institution, between February, 1975, and January, 1977. All procedures were performed by members of a six-man obstetrical and gyneco-

*Falope-Ring™ Applicator, K.L.I., Ivyland, Pennsylvania
**Falope-Ring™ K.L.I., Ivyland, Pennsylvania

logical group. Patients were admitted the evening prior to surgery. Preoperative evaluation included CBC, urinalysis, serology, chest x-ray, electrocardiogram, preoperative anesthetist visit and a preoperative visit by a member of the surgical group other than the operating surgeon. Patients using oral contraceptives and IUCD's had surgery at random times during the menstrual cycle while those using mechanical contraception, with rare exception, had the surgery immediately following menses.

Preoperative medication consisted of Atropine 0.4 mgm. and Demerol 50 mgm. approximately 45 minutes prior to the procedure. All patients underwent general anesthesia and were intubated. Catheterization was performed immediately prior to the procedure and a cervical cannula was inserted. The abdomen was prepped with Betadine. Both the single and double-puncture techniques were utilized.

The standard technique for pneumoperitoneum, insertion of trocar, laparoscope, and other auxiliary instruments was utilized. The fallopian tube is identified and grasped by the tongs at its thinnest portion, usually about three cm. from the cornual end (Figure 1). Care must be taken to include the entire tube. Using the sliding mechanism, the tube is doubled on itself and slowly brought within the hollow central cylinder (Figures 2 and 3). Once this is accomplished, slight additional pressure on the sliding mechanism will cause the outer cylinder to force the silastic band off the central cylinder and around the knuckles of the tube (Figure 4). Reversing the direction of the sliding mechanism will release the tube and the loop of tube with the ring at its base is then easily visualized (Figure 5). Immediate ischemia of the strangulated segment is noted and the whiteness of this segment deepens rapidly under observation (Figure 6). Necrosis of the involved segment occurs, resulting in permanent tubal interruption. Once the tubes are adequately identified, the application takes only seconds.

Several patients had concomitant procedures performed. Postanesthetic recovery was in the general OR recovery room. A standard Darvon order was written for postoperative discomfort and discharge was effected the morning following surgery.

Figure 1.

Figure 2.

Figure 3.

Figure 4.

Figure 5.

Figure 6.

Patient Follow-up

In March, 1977, all office charts were reviewed and all patients contacted by telephone or letter. Table 1 tabulates the 24 months' experience with the Falope-Ring™ sterilizations successfully performed by the laparoscopic technique. Follow-up is calculated in woman months and adjusted for lost-to-follow-up cases and other case losses for indicated reasons. Of 642 attempted cases, 639 were satisfactorily completed and followed for 7,459 woman months. Fifteen cases (2.3 per cent) were lost to follow-up at varying times after

Table 1
Follow-up of 639 Patients Sterilized by the Falope-Ring Procedure

Follow-up (Months)	*Total Cases*	*Woman Months*	Lost To Follow-up		*Other Losses*	*Total Follow-up (Months)*
			Cases	*Woman Months*		
24	19	456	0	0	10°	446
23	23	529	2	46	0	483
22	30	660	1	22	15°°	623
21	20	420	0	0	0	420
20	34	680	1	18	0	662
19	20	380	2	38	0	342
18	27	486	1	13	0	473
17	29	493	0	0	3°°°	490
16	31	496	1	13	0	483
15	26	390	0	0	0	390
14	12	168	1	9	0	159
13	18	234	0	0	0	234
12	26	312	0	0	0	312
11	36	396	0	0	0	396
10	24	240	0	0	0	240
9	14	126	0	0	0	126
8	30	240	1	6	0	234
7	45	315	1	7	5°°°°	303
6	38	228	0	0	0	228
5	34	170	3	13	0	157
4	31	124	1	4	0	120
3	29	87	0	0	0	87
2	18	36	0	0	0	36
1	15	15	0	0	0	15
	639	7681	15	189	33	7459

°Hysterectomy (CIS)
°°Hysterectomy (menorrhagia)
Luteal phase pregnancy (delivered 12-76)
°°°Luteal phase pregnancy (aborted 11-76)
°°°°Hysterectomy (CIS—2 cases)

Table 2
Concomitant Surgical Procedures

D&C	15
Removal of IUCD	13
Cervical biopsy	1
Therapeutic abortion	1
Excision of Gardner's duct cyst	1

the procedure and represent only 2.5 per cent of follow-up in woman months.

Two pregnancies in the study group were recognized and documented at the time of surgery. One underwent abortion on referral to another institution and has been followed for 14 subsequent months, while the second case delivered spontaneously and has been followed also for 14 additional months. No other pregnancies have occurred during the study period.

Tears in the mesosalpinx necessitated three exploratory laparotomies. All occurred in the first three months of use of the instrument, and standard Pomeroy ligations were performed. Two additional tears with bleeding were controlled with application of a second band. The only additional complications were bleeding from puncture sites (four cases), all of which were controlled with through sutures under direct laparoscopic visual control.

Postoperative pain was not a problem and, while no figures are available, it is our opinion that pain was no worse than during four years of cautery sterilization experience.

Table 2 lists concomitant procedures performed at the time of the band application. No difficulties were encountered relating to the primary procedure.

Four hysterectomies were performed at varying intervals subsequent to the ring application. In each case, careful inspection was carried out and the occlusion proved complete with bands *in situ.*

Comments

Falope-Ring™ laparoscopic sterilization has been demonstrated to be both a safe and effective means for female sterilization. It has completely eliminated electrical burns and, although bleeding complications were encountered in five early cases, none has occurred in the past 21 months.

Although other authors report an increased evidence of postoperative pain presumably on the basis of tissue strangulation, this has not been our experience.[3,4] Our exclusive use of general anesthesia may explain this variance.

Luteal phase pregnancies have been reported and, despite careful screening, two cases occurred in our series.[3] In one case, the patient lied concerning her last menses, and the other was an oversight at the time of the preoperative visit. Both cases were firmly documented at the time of the primary procedure and with immediate postprocedure pregnancy test.

No postprocedure ectopic pregnancies have been detected to date; however, maximum follow-up is 24 months. A recent report indicates ectopic pregnancy as a definite complication of tubal ligation and it may occur many months following the procedure.[5] Yoon, King and Parmley[3] have reported a tubo-peritoneal fistula following Falope-Ring™ ligations so that the diagnosis must be considered in post-Falope-Ring™ ligation patients with abdominal pain.

Shortly after we initiated the Falope-Ring™ procedure, one of our patients presented at the x-ray department for in intravenous pyelogram for evaluation of pyelonephritis. Her sterilization had been a demonstration case and a total of five rings had been placed on her tubes. The radiologist reported bizarre pelvic radiolucences resembling "Cheerios in the pelvis." With the increasing popularity of the procedure this will be a common finding in the future.

Acknowledgement

The assistance of Miss Debra Lones and Mrs. Susan Gannett in contacting patients and compiling data is gratefully acknowledged.

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Correction Of Facial Disability

D. VERNE McCONNEL, M. D.
JOSEPH R. CLAWSON, D. D. S.
ROBERT E. BROSSMAN, D. D. S.
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THE basic surgical techniques necessary for the transformation of malformed and deformed facial structures have been available for many years. Some of these techniques are, in fact, so old that they antedate the birth of Christ.

Despite the antiquity of such work, I believe that a significant segment of the general population of physicians is largely ignorant of much that can be done for the facially disabled. Indeed, many of these affected individuals are genuinely and severely disabled. In our contemporary, demanding society with its emphasis upon physical beauty and its accepted cultural mobility, grotesquerie often places stringent limits upon personal achievement.

At this point in time in this country, patients with facial deformity, congenital or acquired. which interferes with an acceptable life pattern should be given the opportunity to seek correction of such a deformity. We believe that it is incumbent upon physicians to realize that the possibility of such correction exists and to bring this possibility to the attention of their patients.

Figure 2. Postoperative profile.

Figure 1. Preoperative profile.

Figure 3. Preoperative full face.

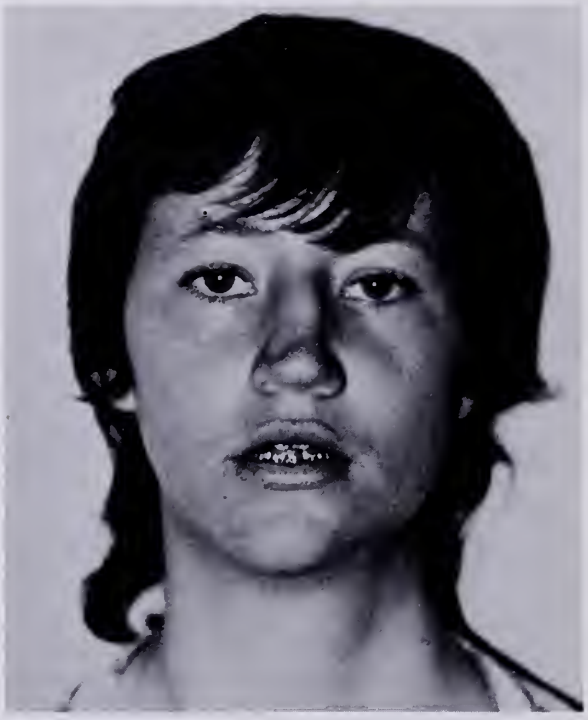

Figure 4. Postoperative full face.

The following case is presented as an example of facial transformation.

Case History

R. W., an 18-year-old, unmarried, Caucasian female high school student, first presented in the local West Virginia Crippled Children's Society Plastic Surgery Clinic on June 26, 1974, complaining primarily of dental malocclusion. Her past history was unremarkable. She was examined by the plastic surgeon, dentists, orthodontists, and oral surgeons. Significant findings consisted of severe prognathism, bilateral hypoplasia of maxillae, and nasal deformity related to the maxillary deformity. A treatment program was outlined and, under the auspices of the West Virginia Crippled Children's Society, she was started upon a program of dental and orthodontic care.

After appropriate orthodontic treatment, the patient underwent a single team operation on August 19, 1975. At this time her mandible was retropositioned, bone grafts were placed on both maxillae, and her gross nasal deformity was revised. The patient's postoperative course was uncomplicated and it is probable that no further surgical care will be needed. The accompanying photographs present the resulting dramatic change in appearance.

Conclusion

Facial appearance can often be markedly improved by combinations of very established surgical techniques.

Reference

Converse JM, Smith B: *Plastic & Reconstructive Surgery,* CB Mosby Co, PO Box 14737, St Louis, Mo 63178.

Use Of Oral Haloperidol Following Rapid Tranquilization Of Acutely Disturbed Patients*

ROY G. CARTER, M. D.
Associate Medical Director, Metropolitan Psychiatric Center, Atlanta, Georgia; and Associate Professor of Psychiatry, Emory University, Atlanta.

THE disruptive symptoms of acutely psychotic patients can be controlled by rapid tranquilization with the butyrophenone haloperidol (Haldol). This method, in which 5 or 10 mg of haloperidol are administered intramuscularly at intervals of 30 to 60 minutes, has been used in recent years to achieve control of acutely disturbed, hostile, and dangerous patients. In a study conducted by Anderson and Kuehnle[1] of Harvard Medical School, 24 acutely psychotic patients were treated with haloperidol, either 10 mg every 30 minutes or 5 mg every 60 minutes. Rapid control of target signs and symptoms was achieved in 11 of the 24 patients within three hours; another five patients were markedly improved after 72 hours.

Between 1973 and 1976, we treated over 100 acutely psychotic patients with haloperidol at the Georgia Mental Health Institute. In 1973, patients were given intramuscular (IM) injections of 10 mg each hour until symptoms were controlled or a maximum of 40 mg was administered. Approximately 60 per cent of the patients treated with this regimen had an excellent clinical response, with prompt and marked decrease in psychomotor agitation, hostility, belligerence, and auditory hallucinations. In 1974, essentially the same regimen was followed, except the maximum total IM dosage was increased to 80 mg. Some 90 per cent of these patients responded. There were no serious cardiovascular reactions in any of the patients treated.

Results of pharmacokinetic[2] studies are consistent with the aforementioned clinical observations. Within 20 minutes after haloperidol was injected intramuscularly into healthy subjects, mean peak plasma concentrations of haloperidol were 4.1 ng/ml (a range of 2.7 to 7.7 ng/ml). Plasma concentrations following IM injection are initially 5 to 10 times those achieved with an equivalent oral dose. Peak plasma concentrations with oral haloperidol are not reached for four to six hours.

Reduction Of Dosage

When patients are switched to oral maintenance after rapid tranquilization is achieved, high doses (60 to 100 mg) given daily at bedtime are frequently required. Once the patient is discharged from the hospital, however, it is often unnecessary to continue treatment with high doses. Reduction of dosage should be made cautiously, however, over a period of weeks, because symptoms of psychosis may reappear quickly if dosage reduction is abrupt. Dosage can be reduced 10 mg every two weeks with careful monitoring of the patient's mental status; decrements less than 10 mg do not appear to be practical. During the period of dosage reduction, the patient should be encouraged to notify the physician if he or she has insomnia or feelings of restlessness, as these symptoms often signal the onset of the more serious manifestations of psychosis.

Extrapyramidal signs (EPS) are uncommon at higher doses, but as the dose is lowered, the anticholinergic action of the drug decreases,[3] and one may expect the appearance of EPS in some patients. In our retrospective study[4] of 48 patients who were tranquilized rapidly, EPS occurred in 14 patients, in each case at doses below the median dose of 30 mg administered in the first 24 hours of treatment.

EPS are readily controlled by the addition of 1 to 2 mg benztropine mesylate (Cogentin) to the regimen, or, in the case of an acute dystonic reaction, by intravenous injection of diphenhydramine 50 mg. Concurrent use of benztropine mesylate may result in decreased plasma levels of haloperidol, in which case the maintenance dose of haloperidol may need to be increased.

Side Effects

At high doses of haloperidol, the side effects of its anticholinergic action include constipation, dry mouth, and blurring of vision due to loss of accommodation. The latter side effect is bothersome to patients; they complain of not being able to read fine print. We have overcome this problem by the administration of two-per cent pilocarpine eye drops three or four times a day.

*Based on a paper presented by the author at the meeting of the West Virginia District Branch, American Psychiatric Association, during the 110th Annual Meeting of the West Virginia State Medical Association at the Greenbrier, White Sulphur Springs, W. Va., Friday, August 26, 1977.

An even simpler remedy, which patients prefer, is the use of inexpensive magnifying eye glasses.

Successful treatment with haloperidol in the posthospitalization period requires close cooperation between physician and patient. Patients should be informed about the symptoms of EPS, particularly the acute dystonic reactions, and advised to report to the nearest emergency room should an occulogyric crisis occur. Reassurance by the physician that these sometimes frightening side effects are easily reversible does much to insure that the patient will follow the regimen prescribed.

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Where reference is made to generically-designated drugs, the first such reference must be followed by parentheses containing the most commonly known trade-name drug of that designation. In addition, a listing of all generic drugs mentioned in the article, with their trade-name equivalents, should appear at the end of the article.

A short abstract summarizing the manuscript should be included. This should be typed in double space on a separate page.

Authors are requested to submit a carbon copy with the original.

Illustrations should be numbered and their approximate locations shown in the text. Each should be identified by placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for reproduction should be done in black (India) ink on pure white. Photographs should be on glossy paper and minimum of about 5 by 7 in. in size. A legend should be provided for each illustration and, preferably, attached to it.

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Medical Grand Rounds

From the West Virginia University Hospital

Edited By
Irma H. Ullrich, M. D.
Assistant Professor of Medicine

The Therapy Of Peptic Ulcer Disease

Discussant:
WILLIAM E. ANDERSON, M. D.
Professor of Medicine and Chairman, Division of Gastroenterology.

At the time of this writing (December, 1977), cimetidine appears to be an effective drug for short-term use in the treatment of active duodenal ulcer. It appears to be approximately as effective as intensive antacid therapy in inducing ulcer healing. It is a valuable drug in the management of the Zollinger-Ellison syndrome and systemic mastocytosis. It shows promise in the prevention and treatment of stress ulceration and for the treatment of pancreatic insufficiency. There is suggestive evidence that chronic use may reduce the incidence of recurrent duodenal ulcer, but it has not been approved for this use at the present time.

It is well to remember that, no matter how effective this new agent may appear to be, we still do not know the underlying reason why an individual develops either a duodenal or a gastric ulcer. We thus are treating only the result of the disease (the ulcer) and not its cause.

THE cause of peptic ulcer disease is usually unknown. There is increasing evidence that an ulcer crater may be the end result of a number of genetic and acquired disorders.[1] If this is true, in the future, the finding of an ulcer will begin, rather than end, the differential diagnostic process, and will lead to the performance of a series of diagnostic tests, much like has been done for hypertension. In the meantime, the therapy of peptic ulcer disease continues to be based on the theory that gastric acid is involved in its pathogenesis, either directly, or indirectly, through the conversion of pepsinogen to pepsin, which requires an acid medium. The mechanism may be the hypersecretion of acid and the formation of an ulcer in a previously normal mucosa (duodenal ulcer), or may be the effect of relatively small amounts of acid in an abnormal mucosa (gastric ulcer). The goals of therapy should involve not only the alleviation of symptoms and healing of the ulcer, but also the prevention of recurrences and complications. There is no question that, up to the present time, our ability to heal the acute ulcer has greatly outstripped our ability to prevent recurrences. Sometimes, this is related to the fact that the original ulcer was never completely healed, but more often is due to the fact that we are unable to treat the causative factor(s) effectively. Whether the availability of newer agents will change this state of affairs remains to be shown. Certainly, the prolonged use of a safe histamine H2-receptor antagonist will severely test the hypothesis that acid secretion is crucial to the development of an ulcer.

Pathophysiology

Over the years, the traditional view of the pathophysiology of peptic ulcer disease has been that a duodenal ulcer is the result of hypersecretion of gastric acid and that a gastric ulcer is the result of a defect in mucosal resistance to acid. A considerable amount of clinical and experimental evidence supports these hypotheses.

Duodenal Ulcer

In spite of much overlap, patients with duodenal ulcers have higher mean basal acid outputs and maximal acid outputs than either normal

individuals or patients with gastric ulcers. They have larger parietal cell masses, which can be estimated by measuring the gastric acid response to maximal doses of histamine or pentagastrin. In addition, these patients secrete more acid after a submaximal stimulus. The cause of this hypersecretion is unknown. This response is not simply a matter of increased gastrin output, since they have normal, or even low, fasting gastrin levels. However, they do secrete increased amounts of gastrin after meals. The very fact that fasting levels are normal in these patients may reflect a relative elevation, since ordinarily the serum gastrin level varies inversely with the amount of acid reaching the gastric antrum. It is of interest that one group of patients with marked hypersecretion of acid but normal gastrin levels, has been reported to have another, as yet unidentified, gastric secretagogue in their blood.[2]

Up to the present, there has been no convincing evidence that there is either inadequate duodenal neutralization of acid or defective duodenal inhibition of acid secretion in patients with duodenal ulcers. The possibility of a deficient pancreatic bicarbonate secretion and incomplete neutralization of acid has been suggested, but no such deficiency has been clearly demonstrated. It seems more likely that a marked excess of acid entering the duodenum could overwhelm even a normal neutralizing mechanism. It has been demonstrated that smoking interferes with pancreatic bicarbonate output and, at present, is a major reason for recommending that patients with duodenal ulcers stop smoking. Although there has been some variation in results depending upon the nature of the test meal, it appears that patients with duodenal ulcers do have more rapid gastric emptying.

In summary, an individual with a duodenal ulcer is likely to have not only an increased capacity for acid secretion, but also for secreting acid at higher rates with or without stimulation. His stomach may empty the acid load more rapidly into the duodenum where neutralization is not sufficient.

Gastric Ulcer

The situation in patients with gastric ulcers appears to be different, at least in the majority of cases. Most, but not all, of these individuals are hyposecretors of gastric acid. In addition, most of them have a gastritis. There continues to be some debate as to whether gastritis produces the ulcer or is due to the ulcer, but there is convincing endoscopic evidence that gastritis is the primary lesion, because it often persists even after the ulcer has healed.

The gastric mucosal barrier to hydrogen ion diffusion can be broken by a variety of agents, such as aspirin, ethanol, and bile acids. This can result in acute hemorrhagic gastritis, superficial erosions, discrete ulcerations or chronic gastritis and gastric ulcer. Patients with gastric ulcers seem to have more back-diffusion than normals or patients with duodenal ulcers, and at least in some instances, this persists after the ulcer is healed.

An attractive hypothesis for the pathogenesis of gastric ulcer is that because of pyloric sphincter incompetence, there is excessive reflux of bile acids from the duodenum into the stomach, with resultant injury to the mucosal barrier, gastritis and ulceration. Pyloric sphincter pressure has been shown to be lower than normal in patients with gastric ulcers, and it also does not respond normally to a variety of stimuli. In addition, many patients with gastric ulcers have increased concentrations of bile acids in their stomachs after feeding.

Other factors, such as mucosal blood supply, defective regeneration of epithelial cells, and a defect in the mucus layer covering the epithelium, may also be important in the pathogenesis of a gastric ulcer. It is known that certain drugs, such as cortisone, aspirin, and indomethacin do have effects on the mucous layer, and carbenoxalone, a drug which appears to hasten the healing of gastric ulcers, does promote mucus formation. However, no consistent defect in gastric mucus has been described in persons with gastric ulcerations.

There has been a strong clinical suspicion that peptic ulcer disease is related to a number of medications, particularly the anti-inflammatory agents. However, for most of them, a cause and effect relationship has been difficult to document. Aspirin has clearly been shown to be related to gastric, but not duodenal, ulcers as well as upper gastrointestinal bleeding. An association between corticosteroid therapy and the development of a peptic ulcer has been difficult to prove, although there is evidence that individuals who receive a total dose equivalent to more than 1000 mg. of prednisone do have an increased incidence of ulcers.[3] Both indomethacin and phenylbutazone break the gastric mucosal barrier, but again, evidence that either causes peptic ulcer disease is lacking. However, these drugs must be used with caution, if at all, in patients who have an ulcer, because of the strong clinical impression that complications may develop.

Incidence

It appears that the incidence of duodenal ulcer has decreased significantly over the past 10 to 15 years. The cause for this decline is unknown, although it makes for some interesting speculation about the role of stress in causing ulcer. There does not seem to have been a similar decline in the incidence of gastric ulcer, and it has been suggested that it has actually increased in frequency. Some of the reported changes in incidence could be related to our improved diagnostic techniques, particularly endoscopy, and the recognition of other disorders that mimic ulcer disease. However, this does not appear to be a major factor.

The familial aggregation of peptic ulcer disease has been established. In some instances, genetic factors seem to be important and, in others, environmental factors, psychologic traits, chronic aspirin ingestion, or cola or cigarette consumption early in life.

The severity of the disease varies greatly from patient to patient. It has been reported that 75-80 per cent of patients with a duodenal ulcer will have recurrent symptoms within five years.[4] In general, duodenal ulcer tends to become less severe as an individual ages, but this is not always the case, and an aggressive duodenal ulcer may be seen in old age. The incidence of gastric ulcer tends to increase with age.

Complications

Since peptic ulcer disease is a disorder with frequent life-threatening complications, and since these complications are often the indication for surgery, it will be of great importance to determine the effect of newer treatments upon the incidence of complications. The incidence of bleeding is probably between 15 and 20 per cent. Some patients are more likely to have repeated bleeding episodes than others, and one-third of patients with a bleeding duodenal ulcer will bleed again within five years. Of those who bleed a second time, two-thirds will have a third hemorrhage within five years.[4] Although it has been claimed that the pattern of bleeding tends to repeat itself (one mild bleeding episode is followed by a second mild episode), there are enough exceptions to this rule to make it of little clinical value.

The incidence of perforation varies greatly in different parts of the world. In this country it is between 5 and 10 per cent. Even without a history of previous symptoms, some 70 per cent of patients who have developed a perforation can be expected to have further trouble, unless initial surgical treatment has been more radical than simple closure of the perforation.

Obstruction has been reported to occur in about 10 per cent of patients hospitalized for duodenal ulcer disease. It is my opinion that at least partial obstruction, which is difficult to recognize clinically, is much more common. Often, however, it is due to inflammation, edema, or spasm associated with an acute ulcer rather than scarring. In such a case, it should respond to medical therapy.

Intractability is the other major complication, and remains the most frequent indication for surgery in duodenal ulcer disease. Obviously, this must necessarily be a subjective diagnosis, and consequently can either be over- or under-diagnosed. Some of these cases are due to complications, such as confined perforation or incomplete obstruction, and some due to unusual entities such as hypergastrinemia or hyperparathyroidism. Some intractable ulcers, however, occur in individuals who are either unable or unwilling to follow a medical regimen. It is the latter group which has a particularly high incidence of postgastrectomy or postvagotomy problems.

A patient with an apparent intractable ulcer should be hospitalized, and the following possibilities considered: (1) unrecognized obstruction, (2) confined perforation, (3) hyperparathyroidism, (4) hypergastrinemia, (5) malignancy, (6) therapeutic nihilism, (7) intractable patient, and (8) mis-diagnosis. When dealing with a gastric ulcer, suspicion of malignancy, either initially because of x-ray or endoscopic findings, or because of lack of healing, is also an indication for surgery.

Therapy

It has always been difficult to measure objectively the effect of any form of therapy for peptic ulcer disease. This has, understandably, led to differences of opinion, even among experts, and has fostered the use of various unorthodox modes of therapy. In addition, it is difficult to find another disorder where so many anecdotes and so much folklore have been substituted for facts, even by knowledgeable physicians.

One of the major problems in the evaluation of any form of therapy has been the fact that most acute episodes of peptic ulceration are self-limited events.

In my opinion, the ordinary patient with an uncomplicated ulcer can be advised to eat a regular diet consisting of three nutritious meals per day. A bedtime snack should be omitted.

Coffee, alcohol, aspirin, and any food known to cause symptoms should be avoided. Milk is a poor antacid, and should not be used at the expense of better ones. Some experts continue to believe that a bland diet is of value, even for an uncomplicated ulcer. I do use a restricted diet when a complication is present, or when ulcer distress does not respond promptly to other measures. I have no quarrel with anyone who prescribes a restricted diet for short periods of time for either a complicated or uncomplicated ulcer. I do not agree with the use of rigid diets over prolonged periods of time.

Antacids

The year 1977 is to be remembered as the year in which cimetidine was approved for use in the therapy of duodenal ulcer disease. It should also be remembered as the year in which convincing evidence of the value of antacids in this disease has been published.[5] In 78 per cent of patients treated with 30cc of antacid one hour and three hours after meals and at bedtime, the duodenal ulcer healed over a four-week period, compared with a 45 per cent healing rate in the placebo group. The relief of symptoms was not significantly different in the two groups. This information, although long suspected clinically, has been a long time in coming. This rate of healing is very similar to the reported response to cimetidine. Whether the combination of antacid and cimetidine will result in an even higher rate of healing remains to be seen. I have recommended that patients with peptic ulcer disease who take cimetidine continue antacids at the same time.

Anticholinergic Agents

Anticholinergic agents have been used in peptic ulcer treatment for a number of years. It has been difficult to prove that they have been of benefit for either treating the acute ulcer, or for preventing recurrences and complications. Since cimetidine reduces meal-stimulated acid secretion by about 67 per cent and propantheline bromide by about 27 per cent, it is clear that cimetidine is superior for that purpose. However, there is evidence that when an anticholinergic agent (isopropamide) and an H2-receptor antagonist (metiamide) are used together that the meal-stimulated acid output can be decreased by about 80 per cent.[6] I personally have never been an enthusiastic advocate of anticholinergics for peptic ulcer disease, mainly because of concern about their effect on delaying gastric emptying. However, the possible value of a combination of an anticholinergic agent and cimetidine needs to be evaluated. In the meantime, I will not be hesitant to use one of these in patients who seem to be resistant to cimetidine.

Cimetidine

Cimetidine, the histamine H2-receptor antagonist now available for clinical use in this country, is effective against basal acid secretion and against all types of stimulated acid secretion.

A histamine H2 receptor antagonist blocks the effect of histamine on the stomach, but does not block the H1 receptors located in the skin, bronchi, or nasal mucosa. The "ordinary" antihistamines, such as diphenhydramine hydrochloride, on the other hand, block the H1 receptors, but have no effect on the H2 receptors in the stomach. There is no question that a majority of duodenal ulcers can be healed when this drug is used. Thus, 71 per cent of duodenal ulcers were healed endoscopically, compared with 37 per cent on placebo.[7] The high response to the placebo (in some studies 60 per cent) is probably influenced by the fact that in these studies an antacid was used as the placebo.[7]

It appears, then, that whether cimetidine or an intensive antacid regime is used, approximately four-fifths of duodenal ulcers should be healed over a four to six-week period. Additional factors to be considered in the choice of a regimen include compliance, safety, prevention of recurrences, and cost. I am certain that many individuals would rather take four tablets of cimetidine per day than seven or more doses of liquid antacid. The nagging question about the safety of cimetidine may yet become a factor. Transient creatinine and SGOT elevations do not seem to be a major problem. Possible endocrine side effects, although not a major clinical problem, include a few cases of gynecomastia in humans, and an increased incidence of Leydig-cell tumors in rats on high doses.[7] Recently, a temporary rise in prolactin levels following intravenous administration of cimetidine has been reported.[8] The significance of these findings is not clear at the time of this writing. Leukopenia, or agranulocytosis, which was a problem with an earlier H2-histamine receptor antagonist (metiamide), has not been a problem up to now. One reported case of leukopenia was apparently due to a peripheral destruction of white cells rather than marrow suppression.[9] One case developed several months after cimetidine had been discontinued, and it may well have been due to another cause.[10] Continued caution is obviously indicated.

At the present time, it is not possible to make conclusions as to the efficacy of any form of

therapy in preventing ulcer recurrence. There is some evidence that cimetidine given on a long-term basis in smaller doses is effective.[7] However, the drug has not been approved for chronic use in duodenal ulcer disease in this country up to the time of this writing.

In addition to the effects of cimetidine on uncomplicated duodenal ulcer disease, many other uses of the drug have been proposed and are now being investigated. The results in gastric ulcers have been somewhat disappointing, and the suggestion has been made that the combination of cimetidine and antacids may be better than either alone.[11] The effect on reflux esophagitis has been somewhat disappointing, in that improvement has not been clearly documented.[12] In acute erosive gastritis, stress ulceration, and upper gastrointestinal bleeding from ulcers or other causes, the answer remains unknown.[13] In one prospective study in patients with grade IV hepatic coma, cimetidine was clearly more effective than intensive antacid therapy in the prevention of gastrointestinal bleeding.[14] In another study, bleeding from erosive gastritis ceased, at least temporarily, in 12 of 13 patients.[15] It is hoped that further studies, soon to be reported, will clarify this issue. There is no question of the value of cimetidine in certain hypersecretory states, such as the Zollinger-Ellison syndrome and systemic mastocytosis. It may well be the treatment of choice in these conditions. In pancreatic insufficiency, cimetidine with pancreatic enzymes was more effective in decreasing steatorrhea and in increasing duodenal enzyme concentration when compared with pancreatin alone, enteric coated pancreatin, or pancreatin with bicarbonate.[16]

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A message from . . .

The President

MID-WINTER IDEA STILL APPEALS

ANOTHER Mid-Winter Clinical Conference, the 11th, is behind us—and No. 12 already is scheduled for January 26-28, 1979, at the Holiday Inn Charleston House in Charleston.

There admittedly is considerable controversy and difference of opinion about continuing medical education programs—the most effective kind of format, how many speakers should speak for how long, the subject matter, voluntary or mandatory requirements for licensure and recertification, etc.

But one thing seems certain—our physicians like the mid-winter conference idea, and the time. Most impressive, as has been the case over the years, was the attendance at all the sessions, coupled with the great number of sharp and helpful questions directed at speakers, and the manner in which those present stayed in the meetings.

One might ask, what else is there to do in Charleston in the late January snow and ice, but the significant fact seems to be that the conference is accomplishing in large measure its most important goal: that of giving practicing physicians from out in the state the kind of information they can take home and start using when they are back in their offices on Monday morning or afternoon.

For all those involved in the planning, it's a tough job that goes on literally the year around, with the final hectic moments coming with a new legislative session under way a few blocks up the street.

But for the obvious benefits resulting, the Program Committee and staff agree it's all more than worthwhile—particularly when, in a group returning evaluation sheets, 64 replied "yes" to a question as to whether such a conference is helpful—with NO negative responses.

JOSEPH A. SMITH, M. D., *President*

The West Virginia Medical Journal

Editorials

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author shall be held entirely responsible.

HSA IN ACTION

Aside from arranging eye-popping salary increases for himself and his principal associates, Mr. James T. Suter, Executive Vice President of the West Virginia Health Systems Agency, and his brigade of health planners have done little to affect one way or the other the cost of health care in West Virginia. We are *not* suggesting that he get busy and expedite the residue of brainstorms which have afflicted his office.

The West Virginia State Medical Association was disappointed, to say the least, in drafts of the proposed State Health Systems Plan submitted by the HSA to us for comment in December. What is particularly alarming about the drafts is the quality of thought, therein displayed, employed to formulate and compose such a critically sensitive document. One would think that anyone so assigned should at least be able to spell correctly the words required to give some appearance of passing familiarity with the subject at hand. And granting even that our educational system leaves something to be desired in assuring proficiency in the use of the English language among its graduates, one has the right to expect that the ability to construct and punctuate a sentence in some acceptable manner would be one criterion of employment for even a health planner.

With regard to an ability to produce quantity of words or tonnage of paperwork, such criteria have been amply, even superlatively, met by our HSA. We would back our own health planners in any contest with others disputing their claim to championship status in producing sheer bulk.

Mr. Suter and his minions have joined enthusiastically with HEW Secretary Mr. Califano in attempting to change Public Law 93-641 from a Health Planning Act into a cost containment measure. The original Act was designed and passed in Congress for the specific purpose of assuring adequate and economical health care personnel and facilities in all areas of the country. The language is clear that health planning should begin at the community level and work from the bottom up. By regulation Mr. Califano and Mr. Suter now attempt to reverse this process and dictate policy to regional planning bodies at the local level.

Rather than assuring access for all to an adequate medical care system through Public Law 93-641, they would now use that law as a vehicle to limit the establishment of any new medical facilities and to strip certain communities of presently available facilities and modes of care. Anyone capable of reading can determine that this is contrary to the express intent of the law.

That such an approach is contrary to the wishes of the people was made abundantly clear during testimony in all parts of the country during public hearings on national health insurance which the administration held this past fall. Repeatedly it was made plain that the people will not accept any system providing less health care than they are now getting. They will tolerate planning, but not at the expense of facilities and care they now have. They are generally satisfied with the present medical care system, and would have any new proposal built on the present system.

Of interest to West Virginia is the fact that our own Governor Rockefeller was briefly a member of the National Advisory Council on Health Planning and Development, a 12-member advisory group mandated by Public Law 93-641 to advise the Secretary of Health, Education and Welfare on planning matters. Governor Rockefeller resigned December 21st. That same day the Council criticized Mr. Califano for publishing inflexible planning guidelines with the sole purpose of limiting health care capacity and to cut costs. We do not know, but we hope, that Governor Rockefeller's resignation was in response to the heed Mr. Califano paid to his advisory council. He did not budge. If such is the case, our estimation of Governor Rockefeller has significantly improved.

Mr. Califano seeks to dictate a policy of scarcity for medical facilities and services and thereby to cut costs. Mr. Suter, reflecting a storm trooper's mentality—"I act on orders from above"—now appears to be following suit in bragging about how many hospitals he will close in West Virginia and how he will cut, pare or eliminate other medical services throughout the state.

Medical care costs can be affected in a variety of ways. They can be driven down dramatically by the simple expedient of padlocking every hospital in West Virginia—a solution with some obvious appeal to Mr. Suter. They can also be driven up by hiring more Suter's and Company in increasing numbers to brew up more home remedy plans for creating cost control and efficiency even as they intrude upon, bog down and stifle presently available medical care.

Mr. Suter and the West Virginia Health Systems Agency are part and parcel of the political system as exemplified by Mr. Califano and the HEW. Every politician knows it is fatal to take something away from the voters without replacing the lost with something which, at least, appears to be of equal value. In this instance, the loss of vitally needed medical care facilities to thousands of West Virginians is apparently to be replaced by the warm feelings of charity and generosity they will feel at the knowledge that Mr. Suter and his small army of medical cost cutters are well paid, comfortable and off the relief rolls.

EDITOR'S NOTE

In view of a widespread, deep and most sincere concern on the part of West Virginia physicians as to just where patient care in this nation is headed, we are offering the following two pieces of correspondence for your close attention. One letter was written by the Medical Association's Executive Secretary to a top official in the West Virginia Health Systems Agency, Inc. The other letter is that official's response to our state office's pointed questions. These letters are offered, along with the editorial comment (above) on the HSA, in an effort to get issues of very significant magnitude into the open. We urge every reader to give serious thought to this material, and to concentrate on obtaining all possible understanding of the real issues at hand—the future of *quality*, *accessible* patient care on *a cost effective* basis for West Virginians, and others in this nation.

January 27, 1978

Mr. William W. Carder
Associate Director for Plan Development
West Virginia Health Systems Agency
815 Quarrier Street, Suite 212
Morrison Building
Charleston, WV 25301

Dear Bill:

Here is another submission of comments on behalf of the West Virginia State Medical Association relative to a component of the proposed State Health Systems Plan. This material represents reaction to the facilities component.

I'm continuing to get expressions of outright dismay about the content, organization, etc., of the plan drafts we have seen. A most common observation is that those involved in developing the drafts have no knowledge or understanding of patient care.

I'm also asked repeatedly what those in the HSA charged with responsibility for the Health Systems Plan are doing with these comments. In other words, are they receiving consideration, and can the medical profession as well as others who actually provide care for the citizens of this State expect to see significant, realistic and practical changes in future material?

I'd appreciate very much as detailed an answer as you might be able to provide to the above two-part question. Review of this material requires a very considerable amount of time; and I repeat, there are very serious expressions of concern among practicing physicians about the eventual impact of any state plan on their ability to give the public and their patients the care their professional judgment, and personal knowledge of their patients, dictate.

With best wishes, I am

Sincerely,
Charles R. Lewis
Executive Secretary

mwh
Enclosure
cc: Mr. James T. Suter

February 2, 1978

Charles R. Lewis, Executive Director
West Virginia State Medical Association
Box 1031
Charleston, West Virginia 25301

Dear Mr. Lewis:

Thank you for bringing to my attention my neglect to thank you for expediting the comments from the Association on the seven discussion papers.

I can understand your concern about similar problems common among the papers. Each of the draft discussion papers was written in the same format. As it turned out, this format has, in and of itself, created several problems in attempting to convey the material in which we were interested in obtaining comment. The draft plan, which we are now preparing, has attempted to correct the format problem.

The comments submitted by you have been reproduced verbatim and distributed to the members of a task force assigned to review all comments received on a particular discussion paper. Your comments along with others were synthesized to derive major points of concern. Particular concern was given to comments relating to particular goals and objectives. In most cases, this synthesis provided the initial agenda at the first meeting of each task force. Additional time was provided for any task force member to bring forth individual concerns not addressed in the synthesis.

Changes in the discussion paper goals and objectives were made in accord with the decisions of the pertinent task force. Some comments were readily adopted by the task forces. Some comments were felt to address symptoms of a concern rather than the underlying issue, and as such, needed changes were made in the underlying issue. Some comments the task forces did not concur with, and as such, the material was left unchanged.

All comments received in time for the first meeting were made available to each task force member. Staff of the West Virginia Health Systems Agency (WV HSA) did not edit or in any way constrain consideration of any comment received. Comments, such as the Association's January 27 letter, which were not received in time for the task force to consider at their first meeting, will be made available to the task force at their second meeting.

It is hoped significant, pertinent changes are being made. Of course, what is pertinent to one group may not be pertinent to another, and as such, needed changes may have been overlooked. This is why we are now developing a draft plan which will be subject to the same review and comment which the discussion papers have undergone. When this draft plan is received, you will be able to determine if your comments created desirable changes, and if not, you are afforded a second opportunity to put forth the case for needed change.

To obtain additional comments on the draft plan, we intend to hold five public meetings in various parts of the state following a 30-day notice in the major papers. This affords an additional opportunity for written and/or oral concerns to be presented. Comments received on the draft plan will again be subject to review by the committees and task forces to determine needed change. Of course, you and other representatives of the Association are welcome at any of our meetings where you could directly present your concerns. I would recommend exercising this right to appear before the Board or its committees if you feel the interests of the Association are somehow being ignored by staff or task forces.

Even when the plan is adopted, I am sure you realize the agency is not empowered to dictate compliance by any deliverer of medical service. However, I do not envision the actions set forth in the plan will in any way adversely affect the practicing physician's ability to give the public and their patients the care their professional judgment dictates. The intent of the plan, and certainly the intent of the agency, is to increase the availability and accessibility of needed medical care. Such an intent with which I am sure the Association agrees.

Again, I personally appreciate the time and effort the Association has taken in reviewing the discussion papers. Again, I apologize for not thanking you earlier for your actions and am sorry you had to resort to a written request to obtain the answer to your concerns. If I can further explain any of the above points or concerns addressed in your letter, please feel free in contacting me.

Sincerely,

William W. Carder
Associate Director
For Plan Development

WWC:dcj

GENERAL NEWS

AMA Practice Management Head Annual Meeting Speaker

Karen Zupko, Director of the American Medical Association's Department of Practice Management, will be in charge of the Saturday morning, August 26, general session of the State Medical Association's 111th Annual Meeting August 23-26 at the Greenbrier in White Sulphur Springs.

Ms. Zupko, a communications specialist, will make presentations on "Personnel: What You Need for Office Efficiency," and "Patient Relationships: Communications, Information, Rapport."

Karen A. Zupko

She has worked in the practice management area for more than three years and has conducted workshops for more than 10,000 medical office personnel in cooperation with more than 75 state and county medical societies and medical assistant organizations nationwide.

A regular participant in the AMA's practice management programs for residents and established physicians, Ms. Zupko also appears on programs for specialty societies, consulting groups, and the Canadian Medical Association. Her articles on practice management have been featured in *Medical Economics* and *Physicians Management* magazines.

A journalism graduate of the University of Kansas, she holds memberships in the American Association of Medical Society Executives, Women in Communications, and the Chicago Junior Association of Commerce and Industry. She is a recipient of the Chicagoland YWCA's Certificate of Leadership.

Annual Meeting activities will get under way with a 2 P.M. meeting of the Association's Executive Committee on Tuesday, August 22; the usual pre-Convention meeting of the Council at 10 A.M. on Wednesday, and the opening session of the House of Delegates at 2:30 P.M. on Wednesday.

An invitation has been extended to Dr. Tom E. Nesbitt of Nashville, Tennessee, who will be installed as President of the American Medical Association in St. Louis in June, to address the Wednesday House session.

It was announced previously that James A. Reynolds, Executive Editor of *Medical Economics*, will deliver the 9 A.M. Thursday, August 24, keynote address. Following will be the Convention's first general scientific session, a "Symposium on New Developments in Treatment of Common Disorders."

The second general session on Friday morning, August 25, will offer papers on high-risk pregnancy, surgical management of obesity and West Virginia's new Medical Examiner System.

The general Convention format once again will provide opportunities for breakfast, luncheon and other meetings, of a scientific and/or business nature, of the various sections and specialty organizations affiliated with the Medical Association. It is anticipated that the bulk of these again will be scheduled on Friday (August 25).

Plans also call for the usual President's Reception on Wednesday evening, August 23, and the Saturday evening reception for new officers. The latter will follow the second and final House of Delegates session at 2:30 P.M. on Saturday which will bring the inauguration of Dr. Robert D. Hess of Clarksburg as President to succeed Dr. Joseph A. Smith of Dunbar.

Members of the Program Committee for the 1978 Annual Meeting are Drs. David B. Gray of Charleston, Chairman; Aarom Boonsue, Point Pleasant; Robert D. Hess, Clarksburg; James T. Hughes, Ripley; Barbara Jones of the West Virginia University School of Medicine faculty in Morgantown and Maurice A. Mufson of the Marshall University School of Medicine faculty in Huntington.

The Annual Meeting of the Auxiliary to the State Medical Association, with Mrs. Joseph T. Mallamo of Fairmont in charge as the Auxiliary's President, again will run concurrently with the Association's Convention.

Legislative Matters Highlight Council's Winter Meeting

Discussion of known and anticipated proposals to come before the 63rd West Virginia Legislature's second regular 60-day session convening in Charleston on January 11 occupied much of the agenda for a January 8 winter meeting of the Medical Association's Council.

In a legislature-related action, Council voted to recommend to the State Senate's Committee on Confirmations that George E. Pickett, M. D., not be confirmed as West Virginia's Director of Health. Council found itself "in an adversary position with regard to Doctor Pickett's philosophy as we perceive it, particularly as it relates to the private practice of medicine. . ."

In other action Council:

Accepted a final 1977 financial report presented by Dr. Kenneth G. MacDonald of Charleston, the Association's Treasurer, showing general operating expenditures for the calendar, and budget, year of $251,172.21, exclusive of outlays for medical scholarships. The Association had budgeted $253,575 for 1977.

Elected to honorary membership in the Medical Association, after corresponding earlier action by component societies, were Drs. Arthur C. Chandler, John E. Lutz and Henrietta L. Marquis, all of Charleston; A. L. Osterman and Howard R. Sauder, both of Wheeling, and A. W. Holmes of Hinton.

Agreed, at the request of Dr. Joseph A. Smith of Dunbar, the Association President, to establishment by Doctor Smith of an ad hoc committee in the general area of pulmonary diseases.

Also agreed, again upon the request of Doctor Smith, to set up an ad hoc committee of the Association's five immediate past Presidents; and assigned to that committee the review of 48 recommendations included in a summary report of a National Commission on the Cost of Medical Care published early in December, 1977.

Directed the Executive Committee to work with Executive Secretary Charles R. Lewis toward an expansion of the State Office staff to cope with steadily increasing responsibilities resulting in large measure from numerous new pieces of federal and state law and administrative regulations.

Approved an allocation of $1,750 to the Auxiliary to the Medical Association for use in developing its program for its annual convention at the Greenbrier in White Sulphur Springs set for August 23-26; and also approved an advance of $300 for prizes for the golf tournament to be held in connection with the Medical Association's annual meeting in August.

Called on the Association's Committee on Constitution and Bylaws to make a general review of the committee structure as set forth in the Bylaws and make appropriate recommendations to an upcoming meeting of the House relative to updating that structure.

170 Brave Bad Weather For Conference

The Eleventh Mid-Winter Clinical Conference, although threatened by winter storms, was held as scheduled January 27-29 at the Holiday Inn Charleston House in Charleston.

Despite weather problems similar to those the year before which then helped reduce attendance to 138, the 1978 total registration was 170, including 151 physicians.

This year's registration also included two psychologists, six interns and residents, six medical students, two nurses and three physician's assistants.

All sessions were held as scheduled, in contrast to last year, when the Friday evening physicians' and public sessions were cancelled because of the weather.

A combination of illness and bad weather prevented the appearance this year of a speaker, John J. Schwab, M. D., of Louisville, Kentucky, Professor and Chairman, Department of Psychiatry and Behavioral Sciences, University of Louisville. Speaking in Doctor Schwab's place was David A. Clayman, Ph. D., Assistant Professor, Department of Behavioral Medicine and Psychiatry, and Coordinator, Consultation - Liaison Services, Charleston Division, West Virginia University Medical Center. Doctor Clayman addressed the subject of dignity in dying.

Despite the weather problems of the past two years, the prevailing sentiment of the attendees this year, both oral and as indicated on evaluation forms, was in favor of continuing to hold the conference during the last week in January. The Program Committee, therefore, has scheduled the 1979 conference for January 26-28 in Charleston at the same location.

Review A Book

The following books have been received by the Headquarters Office of the State Medical Association. Medical readers interested in reviewing any of these volumes should address their requests to Editor, *The West Virginia Medical Journal*, Post Office Box 1031, Charleston 25324. We shall be happy to send the books to you, and you may keep them for your personal libraries after submitting to *The Journal* a review for publication. *Meanwhile, please see reviews of the books, "Medicolegal Aspects of Hospital Records, Second Edition," and "General Ophthalmology, 8th Edition," beginning on page xix of this issue of The Journal.*—Editor.

Coal Workers' Pneumoconiosis—A Critical Review, by Aleksandra J. Kujawska, M. D.; Kazimierz J. Marek, M. D.; and Witold W. Zahorski, M. D. 108 pages. University Press of New England, Hanover, New Hampshire.

Handbook of Pediatrics, 12th Edition, by Henry K. Silver, M. D.; C. Henry Kempe, M. D., and Henry B. Bruyn, M. D. 723 pages. Price $9. Lange Medical Publications, Los Altos, California 94022. 1977.

American Drug Index 1977, by Norman F. Billups, Ph. D., R. Ph. 735 pages. Price $14.50. J. B. Lippincott Company, Philadelphia, Toronto.

Occupational Diseases: A Syllabus of Signs and Symptoms, by E. R. Plunkett, M. D. 352 pages. Price $22.95. The Barrett Book Company, 388 Summer Street, Stamford, Connecticut 06901. 1977.

Medical, Hospital Groups Map Joint Cost Effort

Leadership of the West Virginia Hospital Association and the West Virginia State Medical Association have taken initial steps to join with national counterparts; local hospital governing units and medical staffs, and other health care providers in a nationwide, voluntary cost containment program.

Major goals of the program call for a reduction in the rate of increase in hospital expenditures of two percentage points a year over the next two years; no net increase in hospital beds during 1978, and a reduction in new capital investment during the coming year.

The outline for the voluntary program also has been shared with all of the nation's hospital chief executive officers, chairmen of governing boards and chiefs of medical staffs in recent days. In all, 23,000 letters urging support of the sweeping grass-roots program were mailed by a National Steering Committee formed by the American Hospital Association, American Medical Association and the Federation of American Hospitals.

The national effort developed in response to a November 2, 1977, challenge accepted by the AHA, AMA and FAH from Rep. Daniel Rostenkowski, Democrat of Illinois and Chairman of a U. S. House of Representatives Subcommittee on Health within the House's Ways and Means Committee.

"This historic effort marks the beginning of a new partnership between hospitals and physicians, consumers, suppliers and payers to confront this important national issue (of health care costs)," President John Alexander McMahon of the AHA; James H. Sammons, M. D., Executive Vice President of the AMA, and Executive Director Michael D. Bromberg of the FAH stressed.

The national committee has urged each state hospital and medical association or society to form its own voluntary cost containment committee and put itself in readiness to set up state objectives and goals once certain legal questions regarding some portions of the 15-point national program are resolved.

Joseph A. Smith, M. D., of Dunbar, President of the West Virginia State Medical Association; and James L. Farley of Point Pleasant, President of the West Virginia Hospital Association, said a standing ad hoc committee of their two organizations—made up of the president, past president and president elect of each—will form at least the nucleus for the state committee in West Virginia.

Committee members held their first meeting with regard to their new assignment on January 27, and advised the national group of initial organizational steps. Doctor Smith and Farley said that further development of activity would have to depend in large measure on further guidelines and policy clarification from the national level.

In its communications with hospital administrators and staffs, the national committee reiterated basic points it outlined to Representative Rostenkowski and other members of Congress last fall—primarily, that an intensified, voluntary effort by the nation's health care providers, supplementing various kinds of programs already in place, is the only way in which a slowing of the rise in health care costs can be achieved "while maintaining high-quality health care and equitable distribution of health care services."

ABFP Exam Applications Due By April 1

Applications by family physicians to take the examination of the American Board of Family Practice, Inc. must be received by Dr. Nicholas J. Pisacano's office in Lexington, Kentucky, by April 1, it was announced.

The application is good for two years.

Should the physician fail the examination or for some reason not be able to take it in 1978, the physician may take it on July 7 and 8, 1979.

Applications should be mailed to:

Nicholas J. Pisacano, M. D., Secretary, American Board of Family Practice, Inc., University of Kentucky Medical Center, Annex No. 2, Room 229, Lexington, Kentucky 40506.

Message From Auxiliary To Association

Editor's Note: The following is presented by *The Journal* at the request of the Auxiliary to the West Virginia State Medical Association:

Doctor, is your spouse a member? . . . a member of the American Medical Association Auxiliary, that is. If so, she or he knows the many benefits available—especially the rewards of being active in programs which serve you and the community in which you live. But if not, a real opportunity is going by.

Our members join us because they believe in what we do; because they can be of service; because they appreciate the contacts and companionship; because they can work to correct unfair legislation; because—well, for so many different and worthwhile reasons. Interested, active people are the lifeblood of a growing, active organization like ours.

We know that one person can make all the difference in whether or not things get done. *Just one person. Your spouse!* Won't you encourage her (or him) to join your county auxiliary?

If your county has no auxiliary and you would be interested in seeing your spouses organized, contact our State Membership Chairman: Mrs. D. Sheffer Clark, 241 Whitaker Boulevard, Huntington 25701.

One last word—if you live in an area where it just isn't feasible to have an auxiliary she could join us by becoming a member-at-large. This membership can be obtained by sending your check for $15 dues to our Treasurer, Mrs. Charles S. Harrison, 110 Waverly Way, Clarksburg 26301.

We would most heartily welcome your cooperation in our effort to build membership.

Continuing Education Activities

Here are the continuing medical education activities listed primarily by the West Virginia University School of Medicine for part of 1978, as compiled by Dr. Robert L. Smith, Assistant Dean for Continuing Education. The schedule is presented as a convenience for physicians in planning their continuing education program. (Other national, state and district medical meetings are listed in the *Medical Meetings* Department of *The Journal*.)

The program is tentative and subject to change. It should be noted that weekly conferences also are held on the Charleston and Wheeling campuses as well as in Morgantown. Further information about these may be obtained from: Division of Continuing Education, WVU Medical Center, P. O. Box 2867, Charleston 25330; Office of Continuing Medical Education, WVU Medical Center, Morgantown 26506; or, Office of Continuing Medical Education, Wheeling Division, WVU School of Medicine, Ohio Valley Medical Center, 2000 Eoff Street, Wheeling 26003.

Mar. 11	Morgantown	Annual Conjoint Behavioral Medicine—Internal Medicine Day
Mar. 17, 18	Morgantown	Cancer Teaching Days—Pediatric Oncology
Mar. 25	Wheeling	Seminar on Surgical Problems
Mar. 31	Charleston	Fifth Annual Newborn Day
Apr. 7	Charleston	Behavioral Medicine and Psychiatry Conference
Apr. 8	Parkersburg	Cardiology Teaching Days
Apr. 24	Morgantown	Fourth Annual ENT Teaching Day
May 19, 20	Charleston	Renal Symposium

Program Set For State AAFP Scientific Assembly

The program has been announced for the 26th annual Scientific Assembly of the West Virginia Chapter, American Academy of Family Physicians to be held April 7-9 in Charleston at the Holiday Inn Charleston House.

John A. Thomas, Ph. D.

Maurice A. Mufson, M. D.

The opening session on Friday, April 7, following registration beginning at 7:45 A.M., will get under way at 8:30 A.M. with remarks by Dr. Marshall J. Carper of South Charleston, President of the West Virginia Chapter, AAFP; Dr. Thomas W. Mou, Dean and Professor of Medicine, Charleston Division, West Virginia University Medical Center, and Dr. Asel P. Hatfield of Harrisville, President Elect.

The scientific speakers and topics for the morning session will be "Prostaglandin Update" —John A. Thomas, Ph. D., Associate Dean, WVU School of Medicine, Morgantown; "Hypertension Update"—Roland J. Weisser, Jr., M. D., Assistant Professor, Family Practice, and Charles W. Weart, Pharm. D., Associate Professor of Clinical Pharmacology, WVU, Morgantown, and "Thyroid Function Tests and Their Significance"

C. Andrew Heiskell, M. D.

Robert L. Goldenberg, M. D.

—Stanley R. Shane, M. D., Professor of Medicine, WVU, Morgantown.

Maurice J. Oakley, M. D., of South Charleston will be moderator.

Friday Afternoon

The Friday afternoon program, with Danny R. Wills, M. D., of South Charleston moderating, will include:

"Influenza and Acute Upper Respiratory Infection"—Maurice A. Mufson, M. D., Huntington, Professor and Chairman of Medicine, Marshall University School of Medicine; "Practical Clinical Immunology"—Robert Burrell, Ph. D., Professor of Microbiology, WVU, Morgantown;

"Antibiotic Update"—Raymond M. DeHaan, M. D., Medical Director, Bronson Methodist Hospital, Kalamazoo, Michigan; and "ABFP Certification and Recertification"—Robert M. Blake, M. D., Maysville, Kentucky, Member of the American Board of Family Practice, Inc.

Saturday Morning

Saturday morning speakers and topics will be "Anatomy of Anal and Perianal Area"—James E. Moreland, Ph. D., Chairman, Department of Anatomy, MU School of Medicine; "Office Proctology"—C. Andrew Heiskell, M. D., General and Vascular Surgeon, Monongalia General Hospital, Morgantown;

"Anatomy of the Hand and Wrist"—Doctor Moreland, and "Care of Acute Hand Injuries"—Lawrance S. Miller, M. D., of Morgantown, Clinical Professor of Orthopedic Surgery, WVU.

Moderating will be Gary L. Wagoner, M. D., of South Charleston.

Saturday Afternoon

The speakers and topics for Saturday afternoon will be "Management of Chronic Obstructive Lung Disease"—Murray Sachs, M. D., Clinical Assistant Professor of Medicine, University of Pittsburgh School of Medicine; "Rheumatology Update"—John C. Huntwork, M. D., Assistant Professor of Medicine, MU, and "Diabetic Renal Problems"—H. Howard Goldstein, M. D., Assistant Professor of Medicine, Harvard Medical School, Cambridge, Massachusetts.

Jeanne M. Adams, M. D., of South Charleston will moderate.

Sunday Morning

The final session Sunday morning will include "Fertility and Infertility"—Robert L. Goldenberg, M. D., Assistant Professor of Obstetrics and Gynecology, University of Alabama School of

Medicine, Birmingham; "Update in Office Gynecology"—Euan Gordon Robertson, M. D., Miami, Florida, Professor of Obstetrics and Gynecology, University of Miami School of Medicine, and "Endarterectomy—Who Can Benefit and When"—John D. Harrah, M. D., Associate Professor of Surgery, MU.

Meetings of the Board of Directors will be held on Thursday, April 6, at 7 P.M., and Sunday at 1 P.M.

The House of Delegates will meet on Friday from noon to 1:30 P.M., and the annual banquet will be held Saturday evening.

Annual 'Newborn Day' Scheduled March 31 In Charleston

The fifth annual "Newborn Day," a conference on "Cardiologic Problems in the Newborn," will be held on March 31 at the Charleston Division, West Virginia University Medical Center, 3110 MacCorkle Avenue, S. E.

The sponsors are the Department of Pediatrics of the Charleston Area Medical Center and the Charleston Division, WVU Medical Center.

The program will begin at 8:45 A.M. following registration and a welcome by Herbert H. Pomerance, M. D., Professor of Pediatrics, Charleston Division, WVU, and Chairman of Pediatrics, CAMC.

The moderator for the morning session will be Ricardo Kleiner, M. D., Clinical Assistant Professor, Charleston Division, WVU, and Assistant Chief, Neonatal Services, CAMC.

The speakers and topics for the morning session will be "Physiologic Approach to Cardiopulmonary Problems in the Neonate: I. Blood Gas Transport"—Norman S. Talner, M. D., Professor of Pediatrics and Director, Section of Pediatric Cardiology, Yale University School of Medicine; "Diagnosis and Management of Tachydysrhythmias in the Newborn"—Paul C. Gillette, M. D., Associate in Pediatric Cardiology, Baylor College of Medicine and Texas Children's Hospital, Dallas;

Norman S. Talner, M. D.

"Neonatal Lesions and their Natural History"—Alexander S. Nadas, M. D., Professor of Pediatrics, Harvard Medical School and Chief, Department of Cardiology, The Children's Hospital Medical Center, Boston, and "The Status of Prostaglandins in Neonatal Cardiology"—John F. Tourville, Pharm. D., Assistant Professor of Clinical Pharmacy, WVU School of Pharmacy.

Paul C. Gillette, M. D.

Alexander S. Nadas, M. D.

Dr. Thomas W. Mou, Dean of the Charleston Division, WVU, will be the luncheon speaker.

The afternoon program will include "Physiologic Approach to Cardiopulmonary Problems in the Neonate: II. Congestive Heart Failure"—Doctor Talner; "Diagnosis and Management of Bradydysrhythmias in the Newborn"—Doctor Gillette;

"The Central Nervous System and Its Interactions with the Cardiovascular System"—Norman L. Gootman, M. D., Professor of Pediatrics, State University of New York at Stony Brook and Attending-in-Charge, Pediatric Cardiology Section, Long Island Jewish Hillside Medical Center, New York, and "Cardiac Surgery in the First Year of Life"—Albert D. Pacifico, M. D., Associate Professor, Department of Surgery, University of Alabama in Birmingham.

Nancy C. Wanderman, M. D., Associate Professor of Pediatrics, Charleston Division, WVU, and Chief, Pediatric Cardiology, CAMC, will moderate.

Registrants and their guests are invited to a reception from 5:30 to 7:30 P.M. to be held by Ross Laboratories of Columbus, Ohio. This program is supported in large part by a grant from the firm.

The fee, which includes registration and lunch, is $25.

The program meets the criteria for six and one-half hours of Category 1 credit toward the American Medical Association Physician's Recognition Award, and is approved for .8 Continuing Education Units (CEUs).

April 17 Application Deadline For Humanities Seminars

The National Endowment for the Humanities has announced details of its 1978 Summer Humanities Seminars for Physicians and Other Health Care Professionals. The program brings them and members of other professions together for a month of full-time study in seminars directed by distinguished philosophers, ethicists, historians, and other scholars at selected colleges and universities throughout the country. Its purpose is to help improve the quality of leadership in the nation by giving men and women with practical responsibilities the opportunity to stand back from their work and explore the humanistic dimensions of their professional interests and of important questions of the day.

Three Professional Seminars are open only to physicians and other health care professionals. In addition, five Interprofessional Seminars are offered for them and members of other professions outside of teaching. From 12 to 15 persons attend each seminar tuition-free, receiving a stipend of up to $1,200 plus reimbursement for travel.

The application deadline is April 17. For applications and further information write: Professions Program, Fellowships Division, National Endowment for the Humanities, Washington, D. C. 20506; or contact: Mort Sosna, Donna Orsini Churchwell, or Nancy Norman at (202) 724-0376.

The three Professional Seminars will be "Ethical Issues in Health Care Delivery," July 2-28, Georgetown University; "Individual Rights and the Public Good in Medical Treatment," July 17-August 11, Vanderbilt University, and "The Quest for Professional Ethics in American Medicine: An Historical Exploration," September 11-October 6, University of Texas Medical Branch, Galveston.

MEDICAL WRITING

Experienced medical writer with pharmacy degree will ghostwrite, rewrite, edit or proofread technical or general papers, articles, textbooks, handouts, educational materials etc. Local references available, fees mutually agreed before work commences. J. Marion Anderson, 90 School St., Morgantown WV 26505. Telephone 304-599-9319.

Medical Meetings

March 2-4—International Congress on Colonoscopy and Diseases of Large Bowel, Miami Beach.

March 6-9—Am. College of Cardiology, Anaheim, Calif.

March 10-15—Am. Society of Abdominal Surgeons, Las Vegas.

March 13-16—ACS, Cincinnati.

March 29—April 1—Am. Fertility Society, New Orleans.

April 5-6—W. Va. Chapter, Am. Academy of Pediatrics, Wheeling.

April 7-9—W. Va. Chapter, AAFP, Charleston.

April 24-29—Am. Academy of Neurology, Los Angeles.

April 26-29—W. Va. Academy of Ophthal. & Otolaryn., White Sulphur Springs.

May 3-6—W. Va. Chapter, ACS, White Sulphur Springs.

May 4-7—ASIM, San Francisco.

May 8—Am. Psychiatric Assn., Atlanta.

May 10-12—Med. & Chirurgical Faculty of the State of Md., Hunt Valley, Md.

May 14-17—Am. Thoracic Society, Boston.

May 21-25—Am. Urological Assn., Washington, D. C.

June 10—W. Va. State Society of Anesthesiologists, Morgantown.

June 11-13—Am. Diabetes Assn., Boston.

June 11-15—Am. Society of Colon & Rectal Surgeons, San Diego.

June 17-22—AMA Annual Meeting, St. Louis.

Aug. 23-26—111th Annual Meeting, W. Va. State Medical Assn., White Sulphur Springs.

Sept. 10-14—Am. Academy of Ophthalmology & Otolaryngology (Otolaryngology Section), Las Vegas.

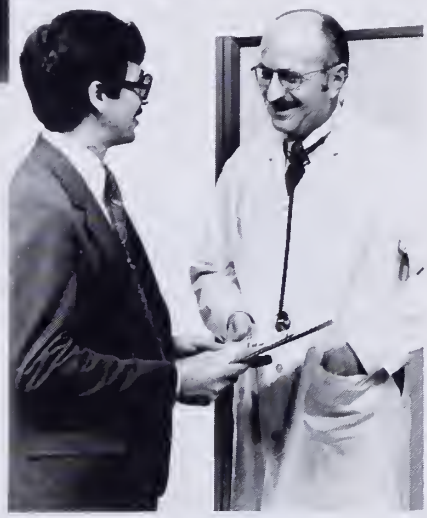
Sept. 25-28—AAFP, San Francisco.

Nov. 11-14—Southern Medical Assn., Atlanta.

1979

Jan. 26-28—12th Mid-Winter Clinical Conference, Charleston.

Working together is the best medicine.



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WVU Medical Center
—News—

Compiled from material furnished by Mrs. Mary Ellin Wylie, Director, Medical Center News and Information Services, Morgantown, W. Va.

Successful Kidney Transplant Performed At WVU

Although still in its formative stages, a statewide kidney retrieval plan has already made possible a successful transplant at West Virginia University Medical Center.

Dr. Marshall Ashby, Assistant Professor of Surgery and Chief of the Renal Transplant Division, said the surgery recently performed on a 49-year-old Beckley man clearly demonstrates the workability of the plan and was the result of close cooperation between the Medical Center and Wheeling Hospital.

The kidney received by University Hospital patient Ray McDaniel was taken by a team of Wheeling Hospital surgeons from a 17-year-old boy following his death in that hospital. It was transported to the Medical Center by West Virginia State Police.

It was the first time that a kidney had been removed in one hospital in West Virginia and transplanted into a patient at another.

Dr. Derrick Latos, a nephrologist, was leader for the Wheeling team which also included urologists Drs. John Franz and David Lindert.

WVU Surgeon Treats 65 At Eye Camp In India

Thanks to a WVU eye surgeon from India, 65 of his compatriots were rescued recently from possible blindness, and countless more with vision problems were examined and treated.

Dr. V. K. Raju used his field of specialization to serve the poor during a four-week holiday in Vijayawada, Andhra Pradesh, his home state in India.

Aided by area doctors, the Vijayawada Jaycees—who organized and set up the free eye camp, and $2,000 worth of medicines and equipment from such United States companies as Alcon, Allergan, Beaver and Ethicon, Raju spent several days examining for, advising about and treating various types of eye diseases. Then, during the next three days, he performed 65 cataract operations and some lid procedures. The remaining time was devoted to follow-up care, and Doctor Raju noted proudly that there was not one case of infection.

"People might tend to think that cataract surgery is performed recklessly under such conditions. Not so. We took all the precautions of asepsis," he said.

Physical Therapy Program Reaccredited By APTA

WVU School of Medicine's baccalaureate degree program in Physical Therapy has been granted continuation of full accreditation for another five years by the American Physical Therapy Association.

An Association team consisting of a physician, an administrator-educator and a clinical therapist conducted a site visit last fall at WVU. The results of their survey and notification of full accreditation from the director of the Association's Department of Educational Affairs recently were forwarded to Marylou Barnes, Professor and Director of Physical Therapy, who said, "We were found to be in conformity with all the essentials for accredited schools."

Some of the approximately 80 physical therapy programs in the nation are recognized for special areas of excellence. "For us, particularly, it was outstanding faculty quality," said Director Barnes, who serves frequently herself as a member of the Association's pool of survey visitors for accreditation of physical therapy programs. She has been director of the WVU division since its inception in 1970.

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Blood Label Requirement Effective May 15

Beginning May 15, all whole blood intended for transfusion will be required to be labeled as coming from either a "paid" or "volunteer" donor.

The labeling regulation, established in January by the Food and Drug Administration, is designed to reduce the risk of transmitting hepatitis through blood transfusions.

Blood from paid donors and commercial blood banks has been shown to be three to 10 times more likely to cause hepatitis than blood from volunteer donors.

Hepatitis is estimated to occur in 10,000 to 30,000 persons annually following blood transfusions.

The new regulation requires that all containers of blood drawn after May 15 be prominently marked either "PAID DONOR" or "VOLUNTEER DONOR."

Donald Kennedy, Commissioner of Food and Drugs, said: "Hepatitis is a costly disease, not only in dollars, but in human lives. At least 400 people die of hepatitis each year, and the cost to treat a single case runs as high as $30,000.

"Blood labels will now provide physicians and their patients with important safety information. This regulation is designed to reduce the life-threatening risks associated with blood transfusions and is consistent with the goal of the government's national blood policy to move toward an all-volunteer blood donor system."

The regulation defines a "paid donor" as a person who receives monetary payment for donating blood. A "volunteer donor" is defined as a person who receives no monetary payment. The regulation specifies that benefits which are not convertible to cash, such as time off from work or membership in blood assurance programs, are not considered monetary payment.

Blood components, including red blood cells, antihemophilic factor, platelet concentrate, and single donor plasma, are also subject to the labeling regulation.

'Poor Patient-Doctor Rapport' Often Cause Of Claim

An important aspect of Aetna Life & Casualty's Loss Control and Education Program, a component in the Medical Association-sponsored professional liability coverage, is the analytical study of malpractice claims in the state being received by the company's Claims Department. An area that continues to surface as what Aetna regards as a cause for many claims is an apparent lack of, or poor, patient-doctor rapport. Aetna representatives believe that the achievement of rapport has been hampered in recent times with the advent of specialization and high expectations of the medical profession on the part of the public.

Studies show that doctors who enjoy good rapport with their patients are less likely to be involved in a suit for alleged medical error. They also show that patients tend to follow their doctors' instructions better if they feel that the doctor truly cares for their welfare, Aetna reported.

A patient can become a claimant because of confusion and misconception over the medical treatment being rendered. If good communication exists between the doctor and patient, this situation can often be easily overcome. The need for rapport extends beyond the patient and includes members of the patient's family. The family has cause to be interested in the care given to the patient and should also be considered when establishing rapport, Aetna has emphasized.

Time and effort are required to establish a good relationship with patients and their families. Some doctors are certain to be more successful than others at the task. Yet, many benefits exist for both doctors and their patients if rapport can be achieved and maintained throughout the course of treatment.

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Obituaries

WILLIAM C. BOGGS, M. D.

Dr. William C. Boggs of Moorefield, a retired dermatologist, died on January 16 at his home there. He was 72.

Doctor Boggs practiced in Wheeling for 42 years before retiring and moving to Moorefield in 1972.

A native of Franklin, he was graduated from West Virginia University and received his M. D. degree in 1931 from the University of Maryland. He interned at Ohio Valley General Hospital in Wheeling and did postgraduate work in dermatology in New York City.

In 1950 and 1951, Doctor Boggs was Secretary and President, respectively, of the Ohio County Medical Society.

He was a Diplomate and Fellow of the American Academy of Dermatology.

A veteran of World War II, he was an honorary member of the Ohio County Medical Society, the West Virginia State Medical Association and the American Medical Association.

Survivors include the widow; a son, William D. Boggs, with the foreign service in Canberra, Australia; a daughter, Mrs. Fred Charles of Ann Arbor, Michigan, and a brother, Dr. Hunter Boggs of Charleston.

* * *

ARCHIE L. STARKEY, M. D.

Dr. Archie L. Starkey of Sun City, Arizona, died on January 6 in a Terra Alta hospital following a long illness. He was 78.

A native of Wallace, in Harrison County, he was graduated from West Virginia University and received his medical education from Harvard University and the University of Arkansas.

Doctor Starkey was a former member of the medical staff at Hopemont State Hospital near Terra Alta, serving as Superintendent and Medical Director from 1948 to 1960. He also was a member of the teaching staff at West Virginia University Medical School during that period.

In 1960, Doctor Starkey joined the Veterans Administration and was on the medical staff at San Fernando (California) VA Hospital, where he remained until the earthquake of February 9, 1971, demolished that institution. During

Continued on page xviii

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County Societies

CABELL

The Cabell County Medical Society met on January 12 at the Gateway Inn in Barboursville.

Dr. Jack Leckie, Chairman of the Legislative Committee, discussed some of the health and medicine bills which were being introduced in the State Legislature. General discussion followed.—Hossein Sakhai, M. D., Acting Secretary.

* * *

FAYETTE

The Fayette County Medical Society met on February 1 at the Oak Hill Hospital.

Visiting speakers were Drs. Charles W. Merritt and Robert P. Pulliam, members of an obstetrics and gynecology group in Beckley. Doctor Pulliam presented a live demonstration of the use of the ultrasonogram in obstetrics, demonstrating with a patient who was 16-weeks' pregnant.—Joe N. Jarrett, M. D., Secretary.

* * *

McDOWELL

The McDowell County Medical Society met on January 10 at the Stevens Clinic Hospital in Welch.

A medical film, "A Fresh Perspective on Pressure," was shown by Mr. John C. Whitmore of Merck Sharp & Dohme. The film, produced at the Cleveland Clinic, reflects the views and guidelines of Dr. Donald G. Vidt, Head of the Clinical Section, Department of Hypertension and Nephrology, at Cleveland Clinic. A short period of discussion followed the film.—Muthusami Kuppusami, M. D., Secretary.

* * *

MONONGALIA

The Monongalia County Medical Society met on January 3 at the Old Mill Club in Morgantown.

The scientific program was presented by Dr. James L. Frost of Morgantown, Medical Examiner for North Central West Virginia. His topic was "Implementation of the West Virginia Medical Examiner System."

Dr. Isaiah A. Wiles discussed the current increase in the number of cases of influenza in the community and national trends. He also encouraged members of the Society to be cognizant of the activities of the West Virginia Health Systems Agency and participate in them.—Barbara Jones, M. D., Secretary.

OBITUARIES (continued from page xvi)

his stay in San Fernando he was associated in a teaching capacity with the University of Southern California and UCLA.

Surviving are the widow, and one sister, Mrs. George Shaw of Fairmont.

* * *

CHARLES H. KEESOR, M. D.

Dr. Charles H. Keesor, retired Wheeling physician, died on January 12 in a hospital there. He was 95.

Doctor Keesor, who practiced for 63 years in Wheeling at one address, was a Past President of the Ohio County Medical Society and served as Medical Director for Ohio County public schools for 25 years.

He received his M. D. degree in 1911 from the University of Maryland School of Medicine.

Doctor Keesor was an honorary member of the Ohio County Medical Society, the West Virginia State Medical Association and the American Medical Association.

Surviving is a daughter, Mrs. Carl H. West of St. Clairsville, Ohio.

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Please contact Mr. Ryan D. Beaty, Executive Director, Northern Panhandle Mental Health Center, Inc., 2121 Eoff Street, Wheeling, W. Va. 26003.

Book Review

MEDICOLEGAL ASPECTS OF HOSPITAL RECORDS, SECOND EDITION — Emanuel Hayt, LL. B., Physicians' Record Company, 3000 South Ridgeland Avenue, Berwyn, Illinois 60402. 519 pages. 1977.

This book (1977) updates the original volume published in 1964, and being more than a dozen years later, contains more recent court decisions that were obscure or undecided in the past.

Dr. John D. Porterfield, Director, Joint Commission on Accreditation of Hospitals, points out that the expansion of this book beyond the original signals to health-care providers and their consultants the growth of importance of the medical record in these litigious days.

The book adequately discusses the problem of incomplete medical records, mentioning that the attending physician is the one responsible for seeing that the medical record is written promptly and accurately. "Unfortunately, he sometimes neglects this duty, feeling he is too busy to do it and puts it off," the book says.

Most hospitals today are not the proprietary kind of years ago, but public institutions, and failure to keep records updated can and does result in staff restrictions or expulsion.

However, another more compelling reason is that where records as made in the regular course of business are received in evidence, it must appear that the records are complete and accurate, and that the entries were made at or about the time the services were rendered.

More and more hospitals are adopting rules that provide for punishing physicians for undue delay in completing medical records. Suspension from the staff is the final decision for complete failure.

The book is especially helpful to orthopedic surgeons and emergency room physicians, as well as good reading for young attorneys just starting practice, nurses, and record-room technicians.

The author, Emanuel Hayt, LL. B., is the same attorney who, in 1940, authored with Lillian R. Hayt, J. D., the book, *Legal Guide for American Hospitals,* which has been a standard work for hospital administrators and physicians for some time.

That book has three chapters dealing specifically with medical records, and the fact that now a whole book is devoted to this one subject is indicative of a growing profession—that of the medical-record person.—Robert J. Wilkinson, Jr., LL. B., Ps. D.

GENERAL OPHTHALMOLOGY, 8TH EDITION — Daniel Vaughan, M. D., and Taylor Asbury, M. D. Lange Medical Publications, Los Altos, California 94022. 379 pages. 1977. Price $12.

Ophthalmology has been a world known only to ophthalmologists for too long a time, with the result that an introduction to this field is a slighted aspect of many clinicians' undergraduate medical preparation. Directing their efforts toward this goal, Doctors Vaughan and Asbury have succeeded admirably in producing a volume, *General Ophthalmology, 8th Edition,* which succeeds, and succeeds well: for the targeted medical students, for generalists, and indeed for ophthalmologists themselves.

There are aspects of ophthalmology which should be known to all practitioners. Many of these are grouped and presented in concise, tabular form, in pictures, photographs and in pertinent text (the Differential Diagnosis of a Red Eye is readily accessible on the inside cover, an indication of its importance). High marks go to the sections on "Physical Examination By The General Physician," the basic equipment section of "The Principles of Management," and especially the pitfalls and dangers involved with local anesthetics, mis-diagnosis, misuse of Atropine, steroids and contaminated medicines, and over-treatment. Worthy of specific mention (Page 220, Figure 17-7) is a method of estimation of anterior chamber angle so that fundus observation through dilated pupils should become commonplace with all physicians, with reasonable assurance of not precipitating an attack of angle closure glaucoma.

Newer techniques which overlie other medical disciplines are covered where these have a direct influence on diagnosis and treatment. The authors have elected to include a separate appendix on computerized axial tonography, evidence of its increasing importance in orbital and neurophthalmologic diagnosis.

There are two shortcomings to this volume. The chapter on strabismus contains the necessary material relating to the subject, but the organization is not as lucid as found elsewhere. The sec-

ond shortcoming is that the clarity of the photoreproduction is uneven, ranging from excellent to poor.

In a world where escalating costs require practitioners to pay exorbitant fees for continuing medical education, we could easily do much worse than the $12 this volume costs and, incidentally, acquire a reference volume into the fascinating world of the visual system.—Walter W. Jones, M. D.

AMA Has New Committee on Services to Young Physicians

The AMA now has an Ad Hoc Committee on Services to Young Physicians. Objectives of the 11-member group are to determine the needs of young practicing physicians in order to recommend the modification of existing AMA activities and creation of new services.

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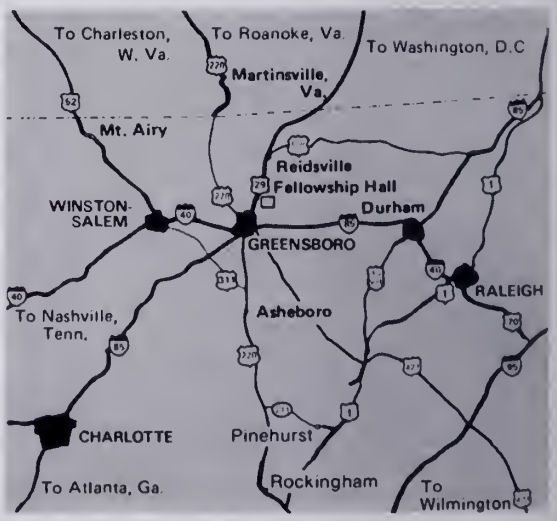

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The West Virginia Medical Journal

Vol. 74, No. 4 April, 1978

Review Article

Updating Biological Depression

JOHN P. D. SHEMO, M. D.
Assistant Professor, Department of Behavioral Medicine and Psychiatry, West Virginia University Medical Center, Morgantown.

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Recent research into the biochemical nature of depression has expanded and refined the catecholamine hypothesis and established a much firmer basis for the biological model of depression. Much of this new data has the potential for altering both our clinical management and our theoretical understanding of this disorder. While the outlined research promises to make the treatment of depression increasingly etiologically oriented, at the present time decisions must still be made largely on the basis of clinical presentations. There are, however, some basic guidelines that have proven quite useful. This article updates recent research and presents basic guidelines for the treatment of biological depression.

In the past decade, there has been an impressive proliferation of new data regarding the affective disorders. This article will attempt to summarize that data which pertains to depression and discuss some of its clinical implications.

Depression—A Symptom

It should be noted that the term "depression" represents not a diagnosis with etiological significance, but rather a descriptive title for a symptom. The patient who presents with the subjective complaint of depression or who is objectively evaluated to be dysphoric, may be suffering from a temporary situational reaction, an "existential crisis," or a true biological depression. Epidemiological data indicate that while most people have occasional dysphoric episodes, the life-time incidence of biological depression is about five per cent in men and 10 per cent in women.[1] Making the correct diagnosis in the case of an individual dysphoric patient has become increasingly important with the increased availability of treatment. For, while significant efficacy can be shown for the antidepressants when they are used appropriately, there is also an associated potential morbidity. The situation is analagous to the treatment of the symptom of edema. Correct etiological diagnosis became more important as progress led from the general treatment of fluid and salt restriction to the present array of more specific treatments, such as digitalis for congestive heart failure and dialysis for renal failure.

The realization that there are prognostically meaningful subtypes of depression has long existed and is reflected in the many historical attempts to delineate such groupings, i.e.: psychotic vs. neurotic, agitated vs. retarded, endogenous vs. reactive, unipolar vs. biopolar, etc. Unfortunately, none of these attempts has provided a clear conceptualization that can be consistently validated clinically. This deficiency has prompted continuing research in the area of depression.

Recent Research Developments

Some of the most significant research developments in recent years have been based on a biological model of depression. The biogenic amine hypothesis of affective disorders (depression = decreased catecholamines) has been valuable in that it has provided a rationale for drug research which led to some useful antidepressant medications. There have, however, been severe re-

strictions placed on the gathering of clinical data with which to refine this hypothesis. This is due to the realization that only one per cent or less of the normally measured urinary breakdown products of the catecholamines is derived from the central nervous system.[2,3] This meant that variables outside of the CNS could easily override even severe CNS disruptions in catecholamine metabolism.

In 1969, a pilot study by Mass and associates demonstrated that diagnostically heterogeneous groups of hospitalized, depressed patients excreted significantly less of the metabolite 3-methoxy-4-hydroxyphenylglycol (MHPG) than did healthy controls, whereas urinary normetanephrine and metanephrine levels were similar in the two groups.[3] The significance of this finding is based upon the knowledge that studies in primates have indicated that approximately half of the MHPG excreted in the urine comes from the metabolism of norepinephrine in the brain,[4] and that MHPG is the principal metabolic product of norepinephrine in the CNS.[5]

Further research into the patterns of MHPG excretion has led to the accumulation of data with the potential for clinical as well as theoretical significance. For example, it has been demonstrated that the excretion of MHPG was not significantly different for several types of depression including bipolar, single-episode unipolar, and recurrent unipolar, whereas each of these subgroups differed significantly from a comparison group of healthy controls.[3] This finding tends to support the concept of depression as a "final common pathway" with various etiologies. It has also been demonstrated that in bipolar patients (manic-depressive) the change in MHPG excretion preceded the behavioral change from depression to mania and vice versa.[3] In answer to the criticism that this change might merely represent a change in the general motor activity of the patient, it has been noted that a change in physical activity sufficient to produce a three- to tenfold increase in peripheral breakdown products of norepinephrine did not alter the MHPG levels.[5] Furthermore, no correlation has been demonstrated between excretion levels of MHPG and such variables as age, height, weight, body surface, creatinine clearance, 24-hour urine volume, or smoking, either in depressed or normal subjects.[3] Nor has the description of the patient as representing agitated or retarded depression been significantly correlated.[3,5]

Perhaps the most interesting data is derived from the finding that while depressed patients as a heterogeneous group exhibit decreased MHPG excretion rates, there is a significant subgroup of patients with all the clinical signs of biological depression who have normal or even high MHPG levels.[3,5] This suggests that perhaps there are subgroups of depressed patients that could be differentiated on the basis of MHPG levels, and indeed a series of elegant research projects has been accomplished which led to just such a proposal.

James Mass, in 1975, postulated the existence of two subgroups of depressed patients which he labeled Group A and Group B.[5] He characterized each as distinguishable on the basis of five characteristics. Group A was characterized as demonstrating: 1. low pretreatment MHPG levels. 2. favorable response to treatment with imipramine (Tofranil) or desipramine (Norpramin). 3. (temporary) brightening of mood following a trial of dextroamphetamine (Dexedrine). 4. modest increment or no change in urinary MHPG level following treatment with imipramine, desipramine, or dextroamphetamine. 5. failure to respond to amitriptyline (Elavil).

Group B was characterized by: 1. normal to high urinary MHPG levels. 2. favorable treatment response to amitriptyline. 3. lack of mood change during trial of dextroamphetamine. 4. decrements in urine MHPG following treatment with imipramine, desipramine, or brief trial of dextroamphetamine. 5. failure to respond to imipramine.

It is of interest that all the pharmacological agents that are effective in treating the Group A patients block norepinephrine uptake, suggesting that Group A patients have a defect in the noradrenergic system.[5] Group B patients have been postulated as having a defect in the serotonin system.[5] In an NIMH-supported study conducted by Beckman and Goodwin, this correlation between pretreatment levels of MHPG and differential response to either imipramine or amitriptyline was found to occur without overlap between the two groups.[4]

Despite the potentially useful clinical implications of this data, there are several complicating problems that have not yet been resolved and integrated. For example, Mendels, Stern, and Frazer found that depletion of brain norepinephrine, dopamine, or serotonin was not in itself sufficient to explain the clinical phenomenon of depression. That is, "no one-to-one relationship (can be) demonstrated to exist between one specific class of neurotransmitters and depressive behavior."[1] This implies that perhaps an alteration in the balance or interrelationship between the various neurotransmitter systems is more

etiologically significant to the development of depression than any change in the activity of an isolated system.[6] Finally, and most unfortunately, to date, the available methods of MHPG determination have proven so difficult and time-consuming [3] that they lend themselves neither to broad studies with large numbers of patients nor to clinical usefulness for the individual patient in the community setting.

Clinical Presentation of Depression

While the research outlined above promises to make the treatment of depression increasingly etiologically oriented in the future, at the present time, treatment decisions must still be made largely on the basis of clinical presentation. There are, however, some basic guidelines that have proven quite useful and are well supported by empirical data.

Perhaps the most basic of these guidelines is that tricyclic antidepressant medications are indicated for the treatment of the "disease" of depression and not the "symptom" of depression. It has been repeatedly demonstrated that patients with the constellation of signs and symptoms representative of biological depression do better with tricyclics while those patients with either the subjective complaint or objective affect of depression, but without the biological signs, do as well or better with placebo as with active drug treatment.[7] The "biological" signs of depression which predict a positive response to tricyclics are generally readily identifiable by history and mental status examination. These positive predictors include the following:[1]

Insidious onset: Biological depression generally does not occur acutely as a reaction to an upsetting event, i.e., the revelation of the existence of an affair involving one's spouse, the loss of a job, etc. An accurate history will often reveal that such events are actually the result of decreased social competency secondary to a long-standing depression rather than the cause of the depression. Frequently, the family will provide the history that the patient has not been functioning well for some time, but has only accepted his depression in the face of the present loss. It is also well to remember that a reactive depression may evolve into a biological depression.

Anorexia: Generally the patient will state that he simply has slowly lost his appetite, and that even when he does eat, the food just doesn't taste good.

Weight loss: A loss of 10 per cent of body weight is considered to be significant.

Middle and late insomnia: The patient states that he goes to bed exhausted, sleeps for a short period of time, then awakens and is unable to return to sleep. Difficulty falling asleep is not statistically as significant a sign of depression.

Diurnal mood variation: The patient states that he feels worse in the early morning with a slight improvement as the day progresses. Anxious patients generally state, in contradistinction, that they feel progressively worse as the day continues.

Psychomotor disturbances: The patient generally will demonstrate evidence of either retardation, such as apathy and slowed response, or agitation, such as pacing, poor focusing of attention, and short temper.

Age over 40: The neurotransmitter system appears to be one of many that becomes more susceptible to disruption with increasing years.

Upper socioeconomic class: This does not indicate that a person of upper socioeconomic class is more likely to become depressed, but rather that such a person who complains of dysphoria is more likely to be biologically depressed and respond to tricyclic antidepressants.

Positive family history: It has been demonstrated that patients are more likely to respond to tricyclics if they have a positive family history of psychiatric illness.[8]

It is of interest to note that such factors as depressed affect, hopelessness, feelings of worthlessness or guilt and suicidal ruminations, while certainly significant and demanding treatment, do not in themselves indicate that the patient is biologically depressed and potentially responsive to medications.

The concept of "masked depression" or "depressive equivalent" particularly merits discussion since, as indicated above, depressed affect is not one of the predictors of response to tricyclics and needs not be present as part of the clinical picture. This is especially true if the patient has a strong need to deny his depression. In such cases, however, symptoms indicative of the biological nature of the disorder (that is, disorders of sleep, appetite, energy level, etc.), should be present and can usually be elicited from the family if not from the patient directly.

Somewhat analagous to the concept of "masked depression" is the well-documented occurrence of physical disease presenting as depression. The

list of disorders that can be included in this category is impressive and includes endocrine disorders, anemias, viral infections, nutritional disorders, tumors, cerebral vascular disease, multiple sclerosis, heart disease and collagen diseases.[9] Generally, the underlying pathology is apparent, although on occasion the depression is among the first symptoms, and the correct diagnosis is made only if the patient is followed in such a manner as to allow continuing reevaluation.

Depression may also be a side effect of several widely used medications such as Reserpine, Aldomet, barbiturates, corticosteroids, and amphetamines.[9]

Treatment

Perhaps the most frequent mistake made in the pharmacotherapy of depression involves the use of either too low a dose or too short a drug trial. Research performed by Glassman *et al* using techniques for the measurement of plasma tricyclic levels has demonstrated that as many as 40 per cent of patients receiving 3.5 mg/kg/day of imipramine HCl failed to achieve therapeutic plasma levels.[8] For a 70-kg man this dosage would convert to 245 mg/day. Currently, it is felt that an adequate trial of tricyclics involves at least three weeks of treatment at 150 mg/day, since a clinical response to tricyclics generally occurs only after a therapeutic plasma level is maintained for an average of 10 days to two weeks. From the data cited above, however, there may need to be a reevaluation as to what constitutes a reliable clinical trial with these agents. Interestingly, there has been recent research which has shown a potential capacity to demonstrate which patients will respond to tricyclics within just a few days by changes in EEG sleep patterns,[10] but these methods are not yet generally clinically available.

Another guideline for the treatment of depression is based on the concept that "depressive illness . . . is the feedback interaction of three sets of variables at chemical, experiential and behavioral levels."[1] This idea is perhaps best supported by the following data: (a) as cited earlier, neurochemical changes artificially induced that mimic the known biochemistry of depression do not invariably produce the clinical symptoms of depression,[1] (b) animal studies suggest that one can induce major changes in the brain amines by selective manipulation of social variables,[1] (c) neurochemical reactions to stress are influenced by rearing conditions.[1] Clinically, this means that the treatment of depression must be approached with multiple therapeutic modalities, and not just medications.

Conclusion

As pointed out by Hollister, "just as a diabetic may be insulin-dependent, but still requires dietary control and strict attention to hygiene, so may the patient with endogenous depression require therapeutic measures complementary to drugs."[11] It is vitally important that we remember that even if no obvious interactional maladjustment or social stress led to the depression, the changes wrought in the patient's functional competency may result in such disruption in his environmental patterns as to severely damage his support systems. In addition, the patient's self concept will likely be altered by his experience with depression so that he may now see himself as vulnerable and somehow defective. This inability of former mentally-ill patients to recover their previous level of self confidence is sometimes referred to as the "demoralization syndrome."[12] Thus, regardless of the "biological" nature of the patient's original illness, he may require a comprehensive program of supportive and even rehabilitative psychotherapy to enable him to regain his premorbid level of adjustment.

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And Now For A Quiz On The Material Presented Above!

(Answers on Page xviii)

1. The life-time incidence of biological depression ranges from:

a. 5 to 10 per cent.

b. 15 to 25 per cent.

c. 30 to 50 per cent.

d. 50 to 75 per cent.

2. Excretion levels of MHPG are directly related to:

a. age.

b. smoking.

c. creatinine clearance.

d. all of the above.

e. none of the above.

3. Which of the following statements about MHPG are correct:

a. MHPG is the major metabolic breakdown product of Norepinephrine in the brain.

b. As much as 50 per cent of the MHPG in the urine is the result of the CNS metabolism of Norepinephrine.

c. Research has demonstrated a potential ability to subdivide usefully depressed patients based on their pretreatment MHPG levels.

d. All of the above.

4. Which of the following statements are not true:

a. Mass' low pretreatment MHPG group responded favorably to imipramine (Tofranil).

b. Mass' low MHPG group responded favorably to desipramine (Norpramin).

c. The normal to high MHPG group responded favorably to amitriptyline (Elavil).

d. The low MHPG group showed either no mood change or became more depressed during a trial with dextroamphetamine (Dexedrine).

5. All of the following "biological" signs of depression predict positive response to tricyclics except:

a. acute onset.

b. weight loss.

c. anorexia.

d. psychomotor disturbances.

6. Biological depression is more frequently indicated when one sees:

a. difficulty falling asleep.

b. insomnia in the middle of the sleep cycle.

c. insomnia late in the sleep cycle.

d. a and b above.

e. b and c above.

7. Which of the following is an indicator for a potentially positive response to tricyclic medications:

a. feelings of hopelessness.

b. feelings of guilt.

c. positive family history for psychiatric illness.

d. suicidal ruminations.

8. Depression has been reported as a side effect of which of the following medications:

a. Reserpine.

b. barbiturates.

c. Aldomet.

d. all of the above.

e. none of the above.

9. Which of the following represents an adequate trial on tricyclics:

a. 100 mg. per day for one week.

b. 100 mg. per day for two weeks.

c. 150 mg. per day for one week.

d. 150 mg. per day for two weeks.

e. 150 mg. per day for at least three weeks.

10. The "demoralization syndrome" would suggest that:

a. high doses of tricyclic antidepressants are necessary to treat depression.

b. hereditary factors are prominent in biological depression.

c. supportive and even rehabilitative psychotherapy may be necessary in addition to antidepressant medication.

d. depression is not a physiological disorder.

Implications of Therapeutic 'Failure' With Tricyclic Antidepressants

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Tricyclic antidepressants (TCADs) are frequently prescribed, but often their complexities are not appreciated. This can lead to labeling patients as tricyclic "failures" when, in fact, the drug trial was inadequate. Six major reasons for the "failures" are given: improper selection of patients, inadequate length of treatment, inadequate dosage, improperly-high dose, improper selection of specific TCAD, and drug interactions. Suggestions are made to avoid these errors. Referral is suggested if these complexities become apparent in a primary-care situation.

ANTIDEPRESSANTS are among the most heavily prescribed and advertised drugs. In the United States, as abroad, by far the bulk of drugs prescribed for depression falls in the class of tricyclic antidepressants (TCADs). While many physicians have a working knowledge of these drugs, the intricacies of their use is often unappreciated, and psychiatrists often find themselves in the position of initiating, modifying, or terminating courses with these medicines. The complaint of the referring physician is often, "the patient just didn't respond to the tricyclic." The purpose of this article is to describe six of the more common reasons for "failure" of TCADs and to suggest methods to avoid these "failures" (Table 1).

I. Improper Selection of Truly 'Depressed' Patients

This is by far the most common reason for "failure" of TCADs. Patients who label themselves as "depressed" certainly constitute a sizeable percentage of all office visits, particularly for primary-care physicians. Only a subgroup of these, however, is amenable to TCAD treatment.

Patients use the term "depression" in a very ill-defined manner, and more detail must be elicited before a decision about TCAD-initiation can be made. Classically, depression has been divided into "endogenous" or "biochemical" as opposed to "exogenous" or "reactive." While this rough schema is far too simplistic for any in-depth usage, it is suitable as a rough guide to tricyclic use. For our purposes, the former category is much more likely to respond to TCADs.

Many patients, particularly those of a primary-care physician, who call themselves depressed are actually dysphoric. That is, rather than being endogenously depressed, they are primarily unhappy, anxious, and perhaps defeated. Most, but not all, cases of marital difficulties, family pathology and interpersonal imbroglios parading as depression fit into this category of dysphoria. These persons respond poorly to TCADs and often do not tolerate their rather potent side effects. Treatment here must be initiated in areas other than TCADs and is beyond the scope of this article.

As compared to the "dysphorics," the "endogenous" or "biochemical" depressive is a good candidate for TCADs. Considerable evidence has amassed to support the biochemical etiology of these drug-responding depressions, particularly in regard to the neurotransmitting catecholamines and indoleamines. Laboratory tests to select out this subgroup are being studied now and are a possibility in the future. Unfortunately, identifying these patients by clinical presentation and symptomatology is not easy, as they often overlap with the group of "dysphorics." This is an exceedingly complex area with many conflicting studies.

Typical of the most recent work is an article by Paykel in which cluster analysis was done on patients entering a TCAD study. The most impressive finding was that "anxious" depressives with neurotic symtoms were the poorest responders.[1] Classical symptoms such as early morning awakening (as compared with difficulty falling asleep), diurnal variation, anhedonia (inability to feel pleasure), and weight loss should be sought, but are not mandatory. Previous epi-

TABLE 1
Possible Reasons for TCAD 'Failure'

I.	Improper selection of truly depressed patients
II.	Inadequate length of treatment
III.	Inadequate dosage (tertiary amines)
IV.	Improperly high dosage (secondary amines)
V.	Improper selection of specific TCAD
VI.	Drug interactions

sodes or family history of affective disease cannot be overemphasized in their importance to differentiate drug responders.

II. Inadequate Length of Treatment

Most physicians are now aware that TCADs require three to four weeks to work. What is less widely appreciated is that 20 days of low dose and then a few days of higher dose does not constitute an adequate trial.[2] TCADs should be initiated at a lower dose, about 75 mgs. per day, then raised over a several-day period. Once-a-day dosage, in the evening, is usually satisfactory.

III. Inadequate Dosage

Inadequate dosage is probably the second most common reason for "failure." For most persons, dosages of the two prototype TCADs, imipramine (IMI) or amitriptyline (AMI), below 150 mgs. per day are simply not adequate.[2] While the relationships between plasma levels and response are still being studied it is probable that for the tertiary amines, IMI and AMI, the response is linear over the usual therapeutic plasma level range.[3] A recent study by Glassman *et al* found that in giving IMI doses of 3.5 mg./kg./day, 40 per cent of the target population failed to reach therapeutic plasma levels.[4] This is a truly astounding figure since they were giving the "70-kg.-man" 245 mgs. of IMI per day.

Another difficulty is that humans receiving the same oral doses of a TCAD develop remarkably variable plasma steady-state levels. Alexanderson has shown that while differences in metabolic rate and plasma levels are affected by exposure to various medicines, the primary factor probably is genetically determined.[6] Again, family history response to TCADs is vital.

The important fact here is that IMI and AMI tend to be prescribed at too low a dose. Safety of dosages greater than 150 mgs./day has been well-documented.[7] Obtaining blood levels of TCADs is increasingly common, and this trend should continue on a selective basis. Relative contraindications such as cardiac disease must, of course, be considered even more seriously when high-dose therapy seems indicated.

IV. Improperly-High Dosage

Too high a dosage of TCADs is also a reason for failure. Although seemingly paradoxical in view of preceding statements, it illustrates the fact that not all TCADs are the same compounds. Unlike the parent tertiary amines AMI and IMI, the secondary amines Nortriptyline and Desipramine (Aventyl and Norpramin) show curvilinear plasma level-response curves (Figure).[3] Therefore, achieving plasma levels above this "therapeutic window" will cause a treatment failure just as too low a level. Some research indicates the typical "failure" on 150 mgs./day of Nortriptyline has too high a blood level and needs a lower dosage,[3] as opposed to IMI failures who probably need higher dosages.

V. Improper Selection of Specific TCAD

Currently, a great deal of research is being done involving subgroups of the "endogenous" subgroup of depressions. Most of this has involved either neurotransmitter research or differential response to AMI vs. IMI. These two TCADs block re-uptake of various neurotransmitters differentially (Table 2).

Neurotransmitter research now indicates that not all "endogenous" depressions are the same, but rather that two or more subgroups of disease exist, possibly depending upon the relative impairment of several amine transmitters. One method of classification utilizes urine levels of 3-methoxy-4-hydroxy-phenethyelene glycol (MHPG), the principal brain metabolite of norepinephrine. One subgroup of depressives has

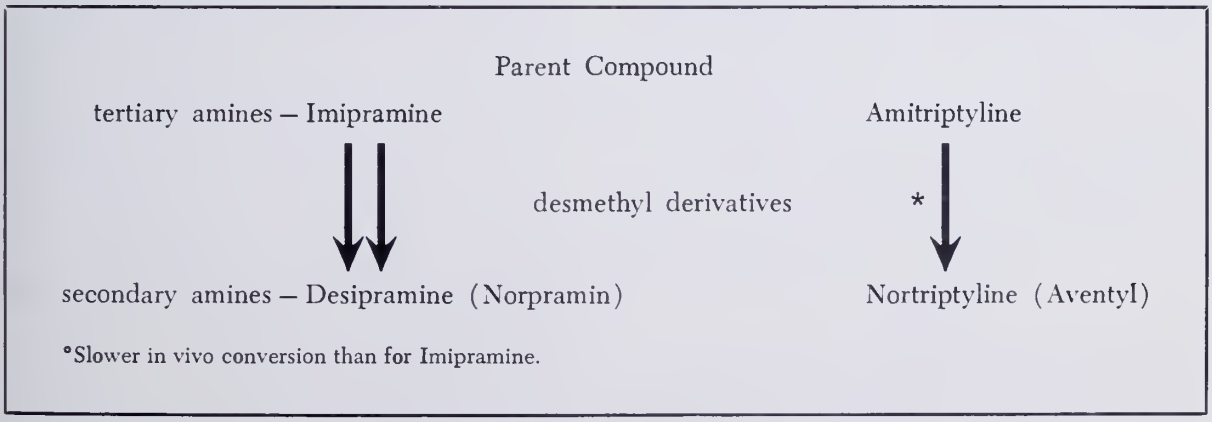

Figure. Basic relationships of major TCADs.

TABLE 2

Effects of Various TCADs on Re-uptake of Biogenic Amines

Drug	*Amine-Serotonin*	*Norepi-nephrine*	*Dopamine*
Amitriptyline	+ + + +	0	0
Nortriptyline	+ +	+ +	0
Imipramine	+ + +	+ +	0
Desipramine	0	+ + + +	0

initially low levels of MHPG and tends to respond to IMI, but not AMI. Another subgroup has initially normal or high MHPG and tends to respond to AMI, but not IMI. The underlying difference between the two groups may be the relative impairment of norepinephrine in the IMI responsive as opposed to serotonin in the AMI responsive, although this has not been proven conclusively (Table 2). There is no known way to differentiate the two groups by symptomatology.

This is significant, since a person who has not responded to an adequate trial of IMI cannot yet be considered a TCAD failure, as he may respond to AMI. Again, past history and family history are crucial. A previous response to a particular TCAD is an excellent predictor of which one to use with subsequent depressive episodes. Tendencies toward selective response to a particular TCAD often are familial (as is depressive disease itself) and most helpful in drug strategy.

VI. Drug Interactions

Drug interactions are of increasing importance in medicine, and the TCADs are no exception. The hepatic enzymes play key roles in tricyclic metabolism. In general, enzyme stimulants can lower drug levels while enzyme inhibitors can raise them. Among the more common drugs that tend to lower TCAD plasma levels are barbiturates, chloral hydrate, alcohol, lithium, and oral contraceptives. Neuroleptics and methylphenidate (Ritalin) raise these levels.

Interestingly, the benzodiazepines (Librium, Valium, Dalmane) have little effect on TCAD plasma levels; and therefore, if a concomitant hypnotic is necessary these would seem to be the drugs of choice as opposed to barbiturates or choral hydrate.[9]

TCADs interfere with the antihypertensive action of Guanethidine (Ismelin) and Clonidine (Catapres). The addition of sympathomimetic amines can lead to hypertension and, rarely, hypertensive crisis.

In summary, TCAD therapy, while often fairly straightforward, has inherent complexities which can lead to confusion and frustration. Referral is probably advisable when these complexities become apparent in a primary-care situation.

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Suture Entrapment Of Femoral Nerve As A Complication Of Inguinal Herniorrhaphy: A Case Report

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Suture entrapment of the femoral nerve following hernia repair has not been reported before in the literature.

This 46-year-old, white male was admitted to the Ohio Valley General Hospital for pain in the groins radiating along the femoral nerve. The pain started following the herniorrhaphy. He underwent surgery and the silk sutures were removed from the femoral nerves. The clinical course and the details of the operations are presented.

IATROGENIC femoral nerve palsy following pelvic surgery[1] due to pressure applied by a retractor on the femoral nerve has been reported, as has femoral neuropathy following anticoagulation[2,3] therapy due to hematoma in the psoas sheath. Suture entrapment of the femoral nerve subsequent to inguinal and femoral herniorrhaphy, however, has not[4,7] been reported. This is the first report of such a case.

The patient is a 46-year-old, white male, well developed and nourished, who had bilateral inguinal herniorrhaphies carried out in November, 1972. On March 2, 1973, he was admitted to the hospital with pain in the left thigh radiating down the leg which he dated from his previous surgery. A diagnosis of femoral nerve palsy was made, and exploration of the left inguinal area revealed five to six silk sutures which had been used for inguinal repair in the femoral nerve. The sutures were removed. Postoperatively, he was improved and was discharged. His femoral pain steadily improved. Then, on January 19, 1974, the patient was readmitted for recurrent, bilateral inguinal hernias. The recurrence on the left side apparently occurred three weeks prior to admission. Exploration of the right inguinal area revealed a combined, femoro-inguinal hernia which was repaired using Cooper's ligament. The patient apparently had no complications from the right-sided herniorrhaphy and was discharged.

On December 3, 1975, the patient was once again admitted for right-sided herniorrhaphy because of recurrence and had surgery under local anesthesia. Postoperatively and after wound-healing, the patient was discharged from the hospital; however, he was readmitted on December 13, 1975, complaining of pain in the right groin radiating to the anterior aspect of the thigh. On December 24, 1975, he underwent a caudal nerve block and injection of the right inguinal canal. The block relieved the pain. He was discharged from the hospital.

On January 15, 1976, he was readmitted because of constant pain in his right groin radiating to the anterior aspect of the thigh and leg which he stated had been present since his repeat right inguinal herniorrhaphy. He stated that the nature of the present pain was similar to that which he had experienced previously in his left groin between November, 1972, and March, 1973, after which the pain in the left thigh gradually subsided, with function returning to the leg.

On examination, he generally was markedly tense, nervous, and stated, "No one can suit me." He had a lack of interest in everything and was confined to bed. He was hypersensitive over the front of the right thigh with maximum tenderness in the right groin over the femoral nerve with quadriceps weakness. Ankle and knee jerks were absent. There appeared to be no weakness in the lower leg, and he was able to have full, pain-free back movements.

An E.M.G. revealed changes in the femoral nerve distribution and, to a lesser extent, in the sciatic nerve. Results of a myelography were essentially negative.

On January 27, 1976, the patient underwent an exploration of the right groin, during which a silk suture was discovered in the femoral nerve and removed. Postoperatively, the patient was improved and was discharged from the hospital to be followed up as an outpatient.

Discussion

The transitional stitch in the piriformis[8] fossa, which is used for direct inguinal herniorrhaphy and infero-medial defects with the use of Cooper's ligament, potentially can entrap the neuro-

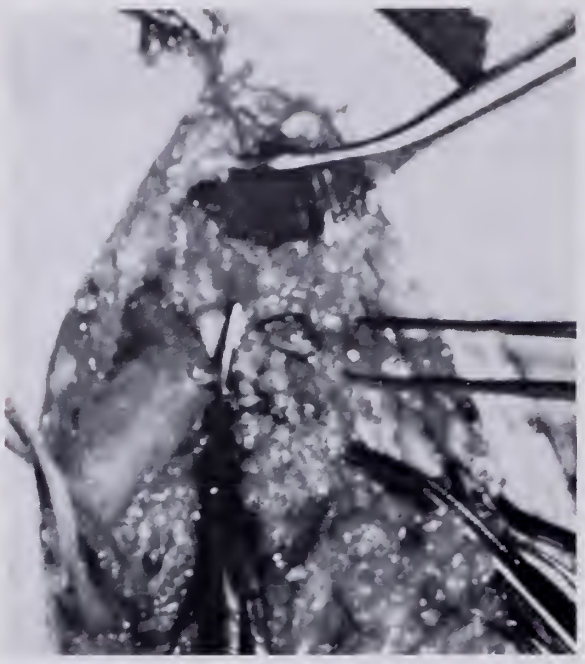

Figure 1. Silk suture in femoral nerve.

Figure 2. The suture was removed.

vascular bundle. Such a complication has not been previously reported.

Another possible complication is abnormality[5,6] and congenital malposition of the femoral nerve which may come under the anterior femoral sheath superficially, rendering the nerve vulnerable to sutures used for approximation of lateral to medial flaps of transversalis[7] fascia. Again, such a complication has not been reported. It is thought that, in this particular case, due to recurrence problems and possibly an attenuated lateral flap, the silk sutures were placed deeply in the inguinal ligament or anterior femoral sheath to achieve a stronger repair, with the end result of entrapment of the nerve.

Summary

The suture entrapment of the femoral nerve as a complication of inguinal herniorrhaphy has not been previously reported. This article deals with a 46-year-old, white male who had such a complication, bilaterally. The herniorrhaphies had been done on separate occasions by different surgeons. Sutures were removed from the femoral nerves two times.

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Special Article

How To Irritate Your Friends And Others

GEORGE E. PICKETT, M. D.
Director, West Virginia Department of Health.

It can hardly have escaped my notice that physicians I have known well for 30 years or more (and a number of other people too) are either angry at me, or puzzled, or both.

They have heard me described as an advocate of public medical care. They may wonder what that, and my job as Director of the reorganized State Health Department, may mean to physicians and patients in West Virginia. The answer is "nothing."

The State Health Department was not reorganized to promulgate national policy, but to improve the management and the substance of the State's public health programs, with the assumption that such improvements, in conjunction with the efforts of thousands of other people, would have a beneficial impact on the health of West Virginians. I accepted the Governor's appointment with that in mind—no more and no less.

I grew up in private practice, rode to house calls all over Monongalia County and on late night emergency trips to Grafton, Clarksburg, Philippi and the northern and eastern Panhandles. That environment, and those experiences, left a deep and lasting impression on me. I saw the best of private practice, of one-to-one care.

As was the case with many others, the changes brought about by Medicare and Medicaid seemed regressive to me. They interjected a bureaucracy between someone who needed help and someone trained to help. They also provided tangible evidence that a growing number of people in the United States felt that everyone should be able to get medical care when they needed it.

The American Medical Association ratified that thesis in the 1969 resolution stating that, "It is the basic right of every citizen to have available to him adequate health care." That declaration, by itself, is not hard to accept. The problem is that rights, by definition, must be protected by a public mechanism, and that means by our government, and no one knows how to do that when talking about medical care.

We do not know how much is enough and who is to decide—the doctor or the patient. We do not know how to measure its quality or whether more is better than less. We do not know who ought to pay for it, and what effect that decision might have on patients, doctors or the national debt.

We do not know how to guarantee a right to something if the producer, in this case a physician, does not think that it is needed, or does not want to treat that particular patient, or wants to treat him or her differently than the patient wants to be treated.

In short, we seem to have accepted the thesis that access to needed health care is a right, but do not know how to implement that concept. Certainly, I do not know how to do it, but I do believe in a few basic principles:

1. The right of access is nearly of common-law status, although no statutory law has declared it to be so. This status is probably essential because we lack the social mechanics to cope with the problems of the indigent and the medically indigent if we treat access as a common market good—i.e., a privilege.
2. Local decision-making and problem-solving are essential in whatever system we develop. National, or even state, management would be too remote and would result in a dehumanizing bureaucracy.
3. General-purpose government, at the state, federal and local level has not been either particularly effective or efficient as a medical care provider. Acceptable and reliable alternatives are needed and, as they are developed, the governmental role should be transferred to the new entity by means of a bilaterally negotiated and publicly ratified contract.
4. Whatever system is developed, it should be implemented slowly, carefully and thoughtfully. It took American medical care 67 years to arrive at its present state of eminence; it should not and cannot be suddenly or radically changed.

Trends and Evolutions

We are slowly moving towards some initial form of national health insurance in the United States. For better or worse, it will probably look at first like the catastrophic health insurance approach advocated by Senators Long and Ribicoff. It will not satisfy people for long and will be altered and expanded. Gradually, we will move closer to universal coverage and comprehensive benefits.

Hopefully, this will not happen until we have a more sucessful experience in answering some of those questions about "How much?," "Who decides?," and "Who pays how much," etc. Of at least equal importance is the need for all of us—physicians, their patients, and concerned government agencies—to develop antibureaucratic, face-to-face, community-based, problem-solving systems. Disputes about those questions must not get caught up in triplicate forms mailed to Baltimore or Columbus or even Charleston (unless the problem arose there!).

I would not want to wager that we can win that battle, but none of us can afford not to try.

It is at about this point that my prognosis begins to differ from that of many of my peers. We have debated so long and so hard about health insurance that it would appear to be some sort of an exhausted end-point to recognize the probable development of a national health insurance program in the United States. Yet, I think it likely that, over the next 30-plus years, the insurance concept will change to a service concept.

The difference between the two is the difference between private, fee-for-service practice and a public or private, non-profit, salaried practice. I am not so much interested in the debate about the good and bad features of these two contrasting forms of practice as I am in making sure that either one can be practiced effectively and efficiently with a minimum of outside interference.

It is not an ideology or a philosophy that prompts my prognosis, but rather a pragmatic analysis of the changes that may occur as we try to implement that thesis that, "It is the basic right of every citizen to have available to him adequate health care."

Insurance systems have to have a balanced budget: income has to equal expenses, more or less. When expenses rise, the insurance system directors must either increase revenue or cut costs.

Revenue can be increased only by increasing the direct and indirect taxes (real taxes and employee-employer agreements) used to fund the plan. Private industry and most governments in the United States have already said, "Enough!," or they soon will.

Costs can be cut only by cutting out benefits, reducing eligibility or applying barriers to utilization. These tactics have failed. They fail more dramatically when the patient is very poor. Such patients have to resort to local charity or local government. At today's prices, neither charities nor governments can or will accept the assignment in full measure.

For these reasons, it is my guess that the insurance aproach to guaranteeing access will ultimately fail. Many people disagree with me, but not most of those who have spent their professional lives studying medical care as a system.

I—and those others—may be wrong. I hope we are.

My reasons for raising the question now have nothing to do with my job as Director of the State Health Department, but rather with my concern for what happens when people sail a single course with such commitment that they fail to see the other wind coming up.

It seems to me to be of great importance that we so structure our approach to the insurance system that we do not leave the principles esential to good care vulnerable to a different approach.

We need to position our health-care practice systems so that the care provided will not suffer due to the mechanisms of national health insurance. We also need to position them so that a future change from an insurance approach to a service approach will not destroy all that has been accomplished so far. To change metaphors, it's like playing pool: play your shot *and* play your leave.

Many of the physicians I have known over the past three to four decades in West Virginia disagree with me. Aand we have had some vigorous discussions. That is okay because they and I learn from such interactions.

One of the most important outcomes of such discussions is the realization that the discussion has no bearing on my job as State Health Director. Changing America's or West Virginia's med-

ical care systems is neither my job nor the purpose of the State Health Department. The job is to help improve the health of West Virginians by aiding and supporting those who have the expertise and the skill to do it.

It would be antithetical to that purpose to advocate an expanded role for state or local government in the direct delivery of medical-care services. Enlarging the capacity of those practitioners and organizations that can do the job is my purpose and my intent.

So, even if you think I have guessed wrong about the next generation, there is probably a lot that we agree on in the years ahead. That is what I intend to pursue and that is why my long-range prognosis about the evolution of medical care in the United States has little significance for the practice of medicine in West Virginia or the programs of the State Health Department.

Quite the contrary, part of my task is to help insure that good, personalized care still be delivered despite the changes that may take place.

Manuscript Information

Manuscripts to be presented for publication in *The West Virginia Medical Journal* should be typewritten, triple-spaced, on one side only of firm (no onion skin or flimsy), standard letter sized (8 1/2 by 11 in.) white paper. Wide margins (at least 1 1/4 in. on left) should be left free of typing. On the first or title page should be shown the title of the article, the name (or names) of the author, and his degrees. Pages should be numbered consecutively, the page number being shown in the right upper corner along with the surname of the author.

Where reference is made to generically-designated drugs, the first such reference must be followed by parentheses containing the most commonly known trade-name drug of that designation. In addition, a listing of all generic drugs mentioned in the article, with their trade-name equivalents, should appear at the end of the article.

A short abstract summarizing the manuscript should be included. This should be typed in double space on a separate page.

Authors are requested to submit a carbon copy with the original.

Illustrations should be numbered and their approximate locations shown in the text. Each should be identified by placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for reproduction should be done in black (India) ink on pure white. Photographs should be on glossy paper and minimum of about 5 by 7 in. in size. A legend should be provided for each illustration and, preferably, attached to it.

All scientific material appearing in *The Journal* is reviewed by the Editorial Board. Manuscripts should be mailed to The Editor, West Virginia Medical Journal, Box 1031, Charleston, W. Va. 25324.

A message from . . .

The President

LET'S GET POSITIVE

THIS is being prepared as another regular session of the West Virginia Legislature is winding down. And once more, unfortunately, the key word for those representing this Association in the legislative halls has been DEFENSE.

It's of course no secret that the health-care system as we have known it is—and has for some years now been—under fire at national as well as state levels. Defensive action thus is a natural, and necessary, response to much of what's going on.

However, this Medical Association continues to display in the legislative arena a shortcoming which has been recognized and discussed, but not remedied. In short, this Association has not developed an effective legislative program as such. It has not decided what it really stands for in its responsibilities to patients and the people of this state.

Each year, time to remedy this vital deficiency becomes shorter. It sounds like a broken record, but doctors have got to get "with it." The crying need is for some specific, POSITIVE, goals and attitudes—and a physician willingness to go to some extra effort to support and promote them.

Let's get on with this particular job and start right now! It's something the public has every right to expect—and demand—of us.

Joseph A. Smith, M.D.

JOSEPH A. SMITH, M. D., *President*

The West Virginia Medical Journal

Editorials

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ANOTHER HEW LIST; AND MORE CONFUSION

The U. S. Department of Health, Education and Welfare is at it again—and once more, is spending substantial amounts of money for the benefit of no one. Specifically, it has directed carriers for Part B, or physicians' services, under Medicare to compile lists of payments to doctors for Medicare services during 1977 that will be useless to the public.

The lists will not show how much physicians actually received; and what they will show will be wide open to question and subject to misinterpretation. HEW delayed this project for some time in January, but then directed the carriers—for West Virginia physicians, Nationwide Insurance—to begin the busy work. The compilation has been scheduled to become available for public inspection—and what some have called "puzzlement"—about April 30 in the offices of the carriers, and at HEW's Baltimore and regional offices.

Those who understand the real nature of the project agree it is full of holes. One problem is that the list will include a figure totaling payments made to all beneficiaries for each physician's non-assigned claims—but the carriers won't be able to verify that the physician identified with the figure ever got the payments from the Medicare beneficiaries served. Another problem is that the figures for both assigned and non-assigned claims will not include Medicare deductible and coinsurance amounts, and the non-assigned claim figures will not show the reasonable-charge reductions.

What's worse, those familiar with Medicare benefits have emphasized, is that each physician who had Medicare patients can be expected to get a letter from the carrier showing these strange figures, and will be asked to report any discrepancies within 30 days. HEW has thus moved to shift the burden of accuracy to the physician—but without giving him the information he needs to find discrepancies. No breakdown of the non-assigned total figure is possible under the Privacy Act.

The American Medical Association has quoted an HEW official that "I don't know that there is any solution to the problem. It is obvious that the doctors cannot reconcile their records with what is posted. If a doctor finds the amount for assigned claims satisfactory, perhaps he will be reassured that the amount shown for unassigned claims is correct, also." This kind of reasoning is highly suspect, to say the least.

The new compilation of payments is an HEW follow-up to the unfortunate and fouled-up listing of last year, which the AMA found to be about 65 per cent inaccurate. After apologizing for his department's work last year, HEW Secretary Califano said he would make sure that "financial information is accurate and relevant" in future lists. The AMA responded that the "issuance of any such lists is an inherent violation of privacy and inevitably results in instances of gross injustice."

Earlier this year, in commenting on the new project, the AMA told HEW it would seem "that an Administration with such a strong public commitment to cost-effective government would seriously question and find lacking the value of such an undertaking." Those words obviously fell on deaf ears at HEW—which, in itself, is not too unusual.

DUPLICITY

The medical profession has long maintained that there is a certain lack of candor on the part of the federal government in dealing with the public on matters of health policy.

This inherent dishonesty has never been more shamefully displayed than in HEW Secretary Califano's efforts to explain his issuance of mandatory guidelines for the implementation of the Health Planning Act (Public Law 93-641). These were eventually withdrawn and modified after a

storm of protest from state governors, thousands of citizens across the country, and a House of Representatives resolution requesting him to withdraw them which passed 357 to 0.

Public Law 93-641 was passed with the clearly-stated purpose of stimulating local planning efforts to assure the provision of adequate health-care personnel and facilities in every section of the country. In issuing the mandatory guidelines Mr. Califano was attempting to reverse the clear congressional intent expressed in the statute by centralizing all planning authority in his own office.

Mr. Califano is an attorney of some excellence and renown. Not the least of his credentials is the fact that his income from the practice of law for the year preceding his acceptance of the job as Secretary of HEW is reported to have been in the neighborhood of $500,000. When the storm broke, statements began emanating from his office and those of various undersecretaries and assistant-secretaries—all to the effect: "Of course the guidelines are not mandatory. My goodness gracious, we understand the law and we do not have statutory authority to make any guidelines mandatory. They were intended merely as guidelines." The mandatory guidelines were then withdrawn and modified.

While this political two-step was being performed, amendments to the Health Planning Act were being drawn up giving to the Secretary the exact authority to mandate local compliance that was lacking in the original law, the lack of which Mr. Califano had tried to circumvent without benefit of law.

These amendments, as embraced in HR10460 and S2410, authorizing centralized health planning from Mr. Califano's office, now rest in Congress—actively promoted and lobbied by HEW staffers—and await passage. These amendments make a mockery of the whole concept of local health planning. Those duped citizens who have in good faith involved themselves and spent countless hours in discussion, planning and making recommendations for local health-care needs are to be used as items in a stage setting for Big Brother's act about to come on stage. Their roles are to be those of spear-carriers in the Shakespearean drama about to unfold.

Benevolent paternalism might be a phrase used by our benefactors in Washington to rationalize such a cynical disregard of ordinary probity. No doubt they honestly believe people cannot be trusted to plan for themselves. But do their charitable concerns about our competence give them a license to be dishonest with us?

AN ANSWER BEFORE IT'S TOO LATE

The AMA-created National Commission on the Cost of Medical Care—in submitting its report with 48 recommendations—has given America a bold and far-ranging statement of *what* has to be done about that cost. And among physicians, there are bound to be *why's*.

* *Why was the commission created?*

Because the AMA recognized the damage and danger inherent in the relentless surge in health-care costs—an average of 11 per cent a year. And because the AMA, as the nation's largest physician organization, was the logical choice to take the lead in curbing that surge and in reducing costs where possible.

* *Why was the commission composed of representatives from a variety of fields—including industry, insurance, labor, government, and academia—instead of being limited to physicians and health-care institutions?*

Because on an issue affecting as many fields and as many people as health-care costs, a panel lacking breadth of membership would also lack credibility. Conclusions reached by persons of like opinion generally excite little attention outside their own group, in contrast with the widely favorable notice the commission report has received in the media and elsewhere. Even so, 11 of the 27 commission members are physicians, and one is a dentist. Thus, the doctors' interests were amply and realistically represented.

* *Why are some of the 48 recommendations at variance with medicine's established way of doing things and even with AMA policy?*

Because *every* group involved directly or indirectly with health care must put cost effectiveness ahead of certain other considerations. To cite examples from the recommendations, experimental payment to hospitals on the basis of prospectively determined rates could be a financial disadvantage to hospitals. Marketplace choice of health-care plans on the part of employees could be a bookkeeping burden for employers.

Responsibility on the part of each segment of health care is integral to working together—and the various segments must act together to act effectively and fairly. They must pull together to head off really tough regulation.

The major thrust of the report is that it calls for mostly voluntary action and has things like this to say about regulation:

"The costs of regulations of all kinds, both governmental and voluntary, have significant impact on the total costs of health care. Govern-

ment, as well as providers of care, must give attention to the simplification of the regulatory process and to consolidating and reducing the number of inspections, audits, surveys, reports, and other mechanisms of enforcement."

The private-sector initiative sparked by the AMA is the way to be our own enforcer in doing what the public wants. Polls show that while most people are satisfied with their medical services, they are uptight about costs—and recognize the impact of physicians on hospital costs, which they resent most.

The AMA House of Delegates will be weighing the commission report at the June annual convention. Naturally the report raises some questions. But it answers the great basic question—*Who is to hold down costs?* It may well be the last bonafide set of answers the health-care world can offer on its own.—*Guest editorial by the American Medical Association.*

IT'S A QUESTION OF MOTIVE

The public is a bit bewildered by the change in attitude of many doctors toward the sick. The physicians of yesteryear are remembered as a selfless group, having much regard for humanity and little for the dollar. Even in today's story books they are pictured as driving sleepily all over the countryside, armed with equanimity and not much else, but devoted. The public would like to get back to that idealized state of medicine. Of course it would not, for a minute, give up any of the miracles of diagnosis and treatment which have been born of this hectic age. But without realizing it, the public would like to have its cake and eat it too.

Changing economic conditions have increased the tempo. Today's doctor treats efficiently more patients per day. With his mind on pathology rather than symptoms, he is exceedingly productive, in the sense of making a lot of people well. He delegates much office, hospital, and laboratory routine. He moves to patients and postgraduate meetings by means of fast cars, trains, and planes. His investment in education, office equipment, and personal goods would stagger the imagination of the old-timers. The government has forced him to account for his income and his expenses. In the interest of personal efficiency and tax requirements, he has had to become a careful business man.

The high standard of living which he enjoys is at once, like the telephone, a boon and a curse. He works so hard that he feels good living is his just reward, but he dare not stop frenetically rushing about, because his expenses will not let him. He has to worry about *noblesse oblige*, insurance against interruptions of income, old age security, high office overhead and his percentage of collections. At his lowest ebb of discouragement some philosophizing patient is sure to remark, "The doctors of today are not like they used to be."

Most of this we grant and, having grown up with the change, charge up most of it to normal evolution. In this headlong rush to adopt themselves to the changing environment, many physicians seem to have forgotten one cardinal principle of medical practice, and it is this: *The physician is made to serve sick people, should there be any. People are not made sick in order to support a physician.* That is why our rules forbid solicitation of patients, advertising, and all the blandishments characteristic of quackery.

If the physician will keep this principle in mind he will not make two visits when one will do. The true physician has been endowed with superior judgment, sensitive discrimination, and a brittle conscience. Of two visits, he will know if one is good for the patient and the other good solely for his pocketbook. He will know that no economy, not even that of the fabulous insurance empires, can stand to leave a patient in a hospital bed longer than strict hospital needs dictate. The idea of using a hospital for a rest is as old-fashioned as sulphur and molasses. The idea of delaying the patient's discharge for personal emolument is just as repulsive. The true physician will know that all these are odorous little tricks which violate the principle that the physician is created to serve the sick, not *vice versa*.

Whether or not these devices are detection-proof, whether or not they are open to public debate, does not mitigate the physician's responsibility to exercise his conscience. He alone is aware of the motive. When motives are of a high order, the medical profession will enjoy the esteem preserved in the illusion of the good old days. When the physician's own welfare is a by-product, and not the prime moving force in medical care, the public will bestow its blessing.—*Massachusetts Physician.*

GENERAL NEWS

Iowa Surgeon, Medical Examiner Annual Meeting Speakers

An Iowa surgeon and the Chief Medical Examiner of the State of West Virginia will be among the scientific speakers during the 111th Annual Meeting of the West Virginia State Medical Association. it was announced by Dr. David B. Gray of Charleston, Chairman of the Program Committee.

Dr. Edward E. Mason of Iowa City, Professor of Surgery at the University of Iowa, and Dr.

Edward E. Mason, M.D.

Irvin M. Sopher, D.D.S., M.D.

Irvin M. Sopher of Charleston will present papers during the second general scientific session on Friday morning, August 25.

The Annual Meeting will be held August 23-26 at the Greenbrier in White Sulphur Springs.

Doctor Mason's topic will be "Surgical Management of Obesity," while Doctor Sopher will discuss "The Medical Examiner System of West Virginia."

Doctor Mason, a native of Boise, Idaho, has held his present appointment at the University of Iowa since 1961, having joined the faculty in 1953 as Assistant Professor of Surgery.

Interest In Gastric Bypass

Among his current projects are the evaluation of gastric bypass in the treatment of obesity, and the use of intravenous glucose and amino acids in the suppression of serum fatty acids and prevention of thromboembolism in obese surgical patients.

His areas of research interest include pneumoperitoneum in preparation for repair of large hernias; nutrition, fluid and electrolyte balance in surgery, and acute renal failure and urinary enzymes.

Certified by the American Board of Surgery, Doctor Mason frequently has lectured on gastric bypass, and has produced exhibits and films on that topic, including the film, "Gastric Bypass and Morbid Obesity," shown and discussed at the 1977 Clinical Congress of the American College of Surgeons in Dallas.

He was graduated from the University of Iowa and received his M. D. degree in 1945 from that institution. He also received a Ph. D. degree in 1953 from the University of Minnesota, at which institution he previously had served his internship and residency in surgery.

Doctor Mason is the author or co-author of 70 scientific articles and abstracts, and also is the author or co-author of 11 books and/or chapters.

Comes From Maryland Post

Doctor Sopher, who also is Clinical Professor of Pathology at the Charleston Division, West Virginia University Medical Center, has been West Virginia's Chief Medical Examiner since August, 1975. He has held teaching positions in Forensic Pathology at Johns Hopkins University and the University of Maryland.

Doctor Sopher is a 1962 graduate of the University of Maryland School of Dentistry and received his M. D. degree in 1966 from that institution's School of Medicine. He then served his internship in General Medicine and Surgery at the University of Maryland Hospital in Baltimore and completed a four-year residency in Anatomic Pathology at that institution in 1971. The latter residency training included a one-year fellowship in Forensic Pathology in the Office of the Chief Medical Examiner, State of Maryland, in Baltimore.

Doctor Sopher is certified by the American Board of Pathology in Anatomic Pathology and Forensic Pathology. From 1971 to 1973, he served as Chief of the Accident Pathology Section of the Armed Forces Institute of Pathology in Washington, D. C. Upon leaving military service in 1973, Doctor Sopher returned to Baltimore where he served as the Deputy Chief Medical Examiner, State of Maryland, until coming to West Virginia.

Doctor Sopher has published some 20 articles relating to Pathology or Forensic Pathology, and is the author of a book, *Forensic Dentistry*, published in 1976.

Two Scientific Sessions

Doctor Gray said there will be two scientific sessions on Thursday and Friday mornings, with the Saturday morning General Session devoted to a program, as announced previously, presented by Karen Zupko, Director of the American Medical Association's Department of Practice Management. Ms. Zupko, a communications specialist, will discuss "Personnel: What You Need for Office Efficiency," and "Patient Relationships: Communications, Information, Rapport."

The first scientific session on Thursday morning, August 24, will be a "Symposium on New Developments in Treatment of Common Disorders." In addition to the papers by Doctors Mason and Sopher during the second scientific session Friday morning, there will be a presentation on high-risk pregnancy. Names of other scientific speakers will be announced in future issues of *The Journal*.

Annual Meeting activities will get under way with a 2 P.M. meeting of the Association's Executive Committee on Tuesday, August 22; the usual pre-Convention meeting of the Council at 10 A.M. on Wednesday, and the opening session of the House of Delegates at 2:30 P.M. on Wednesday.

It also was announced previously that Dr. Tom E. Nesbitt of Nashville, Tennessee, has been invited to address the Wednesday House session; and that James A. Reynolds, Editor of *Medical Economics*, will deliver the 9 A.M. Thursday, August 24, keynote address. Doctor Nesbitt will be installed as President of the AMA in St. Louis in June.

The general Convention format once again will provide opportunities for breakfast, luncheon and other meetings, of a scientific and/or business nature, of the various sections and specialty organizations affiliated with the Medical Association. It is anticipated that the bulk of these again will be scheduled on Friday (August 25).

Plans also call for the usual President's Reception on Wednesday evening, August 23, and the Saturday evening reception for new officers. The latter will follow the second and final House of Delegates session at 2:30 P.M. on Saturday which will bring the inauguration of Dr. Robert D. Hess of Clarksburg as President to succeed

Shown above are some of the speakers in the Eleventh Mid-Winter Clinical Conference held January 27-29 in Charleston at the Holiday Inn Charleston House under the sponsorship of the State Medical Association and the West Virginia and Marshall University schools of medicine. In the left photo, Dr. Charles A. White, Morgantown, standing (left), presided at both the physicians' and public sessions on "Birth Control and Estrogen Update." The speakers were, from left (seated), Drs. David J. S. Hunter, Morgantown; Patrick C. Williams, Jr., Charleston, and E. Noel McIntosh, Morgantown; standing (right), Dr. Narinder N. Sehgal, Charleston. In the right photo, Betty Kirkwood, Charleston, Executive Director of the West Virginia Medical Institute, Inc., and Dr. Harry S. Weeks, Jr. (center), Wheeling, President of the Institute, talk to Dr. William F. Jessee, Baltimore, who spoke on "Your Educational Payoff from Medical Audit" during the Friday evening, January 27, physicians' session. Doctor Weeks presided at this session.

Dr. Joseph A. Smith of Dunbar. Doctor Smith will deliver his Presidential Address at the final House session.

Early Reservations Advised

Meanwhile, reservation forms provided by the Greenbrier have been distributed to all Association members, and those planning to attend the Annual Meeting are encouraged to give them their earliest possible attention.

The Annual Meeting of the Auxiliary to the State Medical Association, with Mrs. Joseph T. Mallamo of Fairmont in charge as the Auxiliary's President, again will run concurrently with the Association's Convention.

Anesthesiologists Schedule Annual Meeting In June

The West Virginia State Society of Anesthesiologists will hold its annual meeting, "Anesthesia Update—1978," on Friday and Saturday, June 9 and 10, at Lakeview Inn and Country Club in Morgantown.

Visiting speakers and their titles will be "Health-Care Legislation in West Virginia"—former Governor Arch A. Moore and Senator Jennings Randolph; "Premedication and Supplementation for Regional Anesthesia"—Phillip O. Bridenbaugh, M. D., Chairman of Anesthesiology, University of Cincinnati;

"Anesthesia and the Heart"—Henry L. Price, M. D., Chairman of Anesthesiology, Hahnemann Medical College; "The Effect of Sodium Nitroprusside and Propranolol on Regional Blood Flows"—Mark B. Ravin, M. D., Chairman of Anesthesiology, University of Kentucky, and "Balance in Modern Anesthesia"—C. Ronald Stephen, M. D., Chairman of Anesthesiology, Washington University.

West Virginia University Medical Center (Department of Anesthesiology) speakers and topics will include "Anesthesia As An Environmental Hazard"—Yadin David, M. Sci., Research Instructor, Biomedical Engineer; "Total Anesthetic Management of Patients with Massive Abdominal Tumors"—Juan F. Gutierrez, M. D., Associate Professor;

"Choice of Local Anesthetics in Obstetrics"—Roland L. Kennedy, M. D., Professor, and "The Application of a Hand-Held Computer for the ICU"—John J. Rick, M. D., Associate Professor.

For further information contact: Richard B. Knapp, M. D., Secretary/Treasurer, WVSSA, c/o Department of Anesthesiology, WVU Medical Center, Morgantown 26506.

Review A Book

The following books have been received by the Headquarters Office of the State Medical Association. Medical readers interested in reviewing any of these volumes should address their requests to Editor, *The West Virginia Medical Journal*, Post Office Box 1031, Charleston 25324. We shall be happy to send the books to you, and you may keep them for your personal libraries after submitting to *The Journal* a review for publication. *Meanwhile, please see review of the book, "Handbook of Poisoning, 9th Edition," on page xvii.*—Editor.

Coal Workers' Pneumoconiosis—A Critical Review, by Aleksandra J. Kujawska, M. D.; Kazimierz J. Marek, M. D.; and Witold W. Zahorski, M. D. 108 pages. University Press of New England, Hanover, New Hampshire.

American Drug Index 1977, by Norman F. Billups, Ph. D., R. Ph. 735 pages. Price $14.50. J. B. Lippincott Company, Philadelphia, Toronto.

Occupational Diseases: A Syllabus of Signs and Symptoms, by E. R. Plunkett, M. D. 352 pages. Price $22.95. The Barrett Book Company, 388 Summer Street, Stamford, Connecticut 06901. 1977.

New CHAMPUS Contractor For West Virginia

Effective March 1, Mutual of Omaha Insurance Company began processing all claims for professional and institutional care received in Ohio and West Virginia by beneficiaries of the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), United States Department of Defense. The company previously processed professional claims from Ohio only.

Mutual of Omaha was selected on the basis of competitive bidding. The organization submitted the best overall proposal for administering payments of CHAMPUS claims for the two states, according to Defense Department officials.

Affected CHAMPUS beneficiaries were to begin submitting claims to Mutual of Omaha after February 28, 1978, even if the care was received before that date. The address is: 3301 Dodge Street, Omaha, Nebraska 68131.

EENT Meeting April 26-29 At The Greenbrier

The National Spring Meeting of the West Virginia Academy of Ophthalmology and Otolaryngology will be held April 26-29 at the Greenbrier in White Sulphur Springs.

Speaking for the ophthalmology program will be Drs. Robert C. Drews, Clayton, Missouri;

Bruce E. Spivey, M. D.

Bradley R. Straatsma, M. D.

Jared M. Emery, Houston, Texas; Richard P. Kratz, Van Nuys, California; Bruce E. Spivey, San Francisco, and Bradley R. Straatsma, Los Angeles.

Otolaryngology speakers will be Drs. William Jaquiss and Donald Kamerer, both of Pittsburgh, and Drs. Walter P. Work, Ann Arbor, Michigan, and Charles T. Yarington, Seattle.

Checks for the registration fee of $225 should be payable to The West Virginia Academy of Ophthalmology and Otolaryngology and addressed to Dr. J. Elliott Blaydes, The Blaydes Clinic, Frederick Street, Bluefield 24701.

Room reservations should be made directly with the Greenbrier.

Cardiac Life Support Course In May

"Advanced Cardiac Life Support Instructor Course," a two-day course, will be held by the American Heart Association, West Virginia Affiliate May 17-18 in Morgantown.

The course is designed to complement the accepted, standard, basic life-support course and to present an overview of the knowledge and techniques used to manage a cardiac emergency. It is both a review for those familiar with acute cardiac care and an introduction for those who seldom care for the patient with a life-threatening cardiac disturbance.

Registration is open to physicians, registered nurses and mobile intensive-care paramedics. Reservations should be sent to: West Virginia Heart Affiliate, 211 - 35th Street, Charleston 25304.

Continuing Education Activities

Here are the continuing medical education activities listed primarily by the West Virginia University School of Medicine for part of 1978, as compiled by Dr. Robert L. Smith, Assistant Dean for Continuing Education. The schedule is presented as a convenience for physicians in planning their continuing education program. (Other national, state and district medical meetings are listed in the *Medical Meetings* Department of *The Journal.*)

The program is tentative and subject to change. It should be noted that weekly conferences also are held on the Charleston and Wheeling campuses as well as in Morgantown. Further information about these may be obtained from: Division of Continuing Education, WVU Medical Center, 3100 MacCorkle Avenue, S.E., Charleston 25304; Office of Continuing Medical Education, WVU Medical Center, Morgantown 26506; or, Office of Continuing Medical Education, Wheeling Division, WVU School of Medicine, Ohio Valley Medical Center, 2000 Eoff Street, Wheeling 26003.

Apr. 8	Parkersburg	Cardiology Teaching Days
Apr. 15	Wheeling	Update on Medical and Surgical Management of Biliary Tract Disease
Apr. 24	Morgantown	Fourth Annual ENT Teaching Day
May 19, 20	Charleston	Renal Symposium
June 3	Charleston	Fifth Annual White-Water Surgery Conference
June 17	Morgantown	Common Arrhythmias and Their Management

Association, WVU To Join AMA For Air Pollution Course

A one-day course on "Air Pollution and Health Effects" will be sponsored by the American Medical Association in Charleston on May 6 in the Auditorium of the Charleston Division, West Virginia University Medical Center.

Physicians from four states will participate in the program, which is co-sponsored by the State Medical Association and the Charleston Division, WVU.

Douglas I. Hammer, M. D., D. P. H., of Chapel Hill, North Carolina, will be the course director. Doctor Hammer is Adjunct Assistant Professor of Epidemiology at the University of North Carolina School of Public Health.

Accredited By AMA, AAFP

The continuing medical education activity meets the criteria for seven credit hours in Category 1 of the Physician's Recognition Award of the AMA—and is acceptable for five Prescribed hours by the American Academy of Family Physicians.

Registration will begin at 8 A.M., followed by welcomes and introductions at 9 o'clock and opening remarks by Doctor Hammer at 9:15.

The welcomes and introductions will come from Frank W. Barton, LL.B., of Chicago, Associate Director, Department of Environmental, Public, and Occupational Health, AMA; Dr. Joseph A. Smith of Dunbar, President of the State Medical Association, and Dr. Thomas W. Mou. Dean of the Charleston Division, WVU Medical Center.

EPA Speakers

The speakers and topics for the scientific program, beginning at 9:30 A.M., will include:

"The Nature of Air Pollution in the United States"—Gerald G. Akland, Chief, Statistical & Technical Analysis Branch, Environmental Monitoring and Technical Support Laboratory, Environmental Protection Agency (EPA), Research Triangle Park, North Carolina; Meteorological Aspects of Air Pollution in West Virginia"—Donald E. Risher, Meteorologist. Kanawha County Airport, Weather Service Forecast Office, Charleston;

"Air Pollution and Pulmonary Physiology"—David W. Cugell, M. D., Bazely Professor of Pulmonary Diseases, Northwestern University Medical School, Chicago, and "Scientific Basis for Public Health Control of Environmental Hazards"—Irvine J. Selikoff, M. D., Director, Environmental Sciences Laboratory, Mt. Sinai School of Medicine, New York City.

Dr. George E. Pickett, Director of the West Virginia Department of Health, will be the luncheon speaker.

Film, Panel Included

Speaking during the afternoon program will be Dr. Robert S. Chapman, Medical Officer, Epidemiology Branch, Health Effects Research Laboratory, National Environmental Research Center, EPA, Research Triangle Park, North Carolina,

Speaking at the session on "Behavioral Medicine and Psychiatry Update" during the Eleventh Mid-Winter Clinical Conference held in late January in Charleston were, in the left photo (from left), David A. Clayman, Ph. D., and Arthur E. Kelley, M. D., both of Charleston, and Paul L. Crawford, Ph. D., Institute. Dr. Mildred Mitchell-Bateman (right), Huntington, presided. In the right photo are the speakers for the "Symposium on Infections." They are, from left, Drs. H. Bradford Hawley, Warren Point and Charles W. Stratton, all of Charleston.

on "EPA Current Health Research;" and Dr. William K. C. Morgan, Professor of Medicine and Chief, Pulmonary Division, WVU Medical Center, Morgantown, on "Occupational Lung Diseases."

The afternoon session also will include a film entitled, "Air Pollution, The Facts," and a panel discussion on "Physician's Role in Air Pollution." The moderator will be Dr. Joseph T. Skaggs of Charleston.

Adjournment will follow closing remarks by Doctor Hammer at 5 P.M.

The registration fee of $40 includes syllabi and luncheon.

WVU Ob-Gyn Visiting Professor In Morgantown May 11-12

Dr. William C. Keettel of Iowa City, Iowa, will be at the West Virginia University Medical Center on Thursday and Friday, May 11 and 12, for the Visiting Professor series of the Department of Obstetrics and Gynecology.

Doctor Keettel is Professor and Chairman Emeritus of Obstetrics and Gynecology at the University of Iowa.

He will talk on "Management of Serious Infections Following Cesarean Section" and "Chronic Vulvar Dystrophy—Current Concepts."

Visiting Professors participate in Departmental Grand Rounds at 2 P.M. on Thursday. Their scheduled presentations are given at 4 P.M. Thursday and at 7:30 A.M. Friday.

This continuing medical education offering meets the criteria for eight hours of credit in Category 1 toward the Physician's Recognition Award of the American Medical Association—and for 0.8 WVU Continuing Education Units (CEUs).

The final Visiting Professor in the 1977-78 series will be Dr. George Morley of Ann Arbor, Michigan, who is scheduled for Thursday and Friday, June 8 and 9.

Doctor Morley is Professor of Obstetrics and Gynecology at the University of Michigan. His presentations will be entitled, "Physical Finding: An Adnexal Mass!" and "Why Radical Pelvic Surgery?".

No registration fee is charged for this series.

For additional information contact Dr. Charles A. White, Professor and Chairman, Department of Obstetrics and Gynecology, WVU Medical Center (telephone 304-293-5631).

Doctors Skaggs, Arceo Named By Allergy Foundation

Dr. Joseph T. Skaggs of Charleston recently was appointed as volunteer Medical Director of the Allergy Rehabilitation Foundation, Inc., the nonprofit sponsor of Bronco Junction, rehabilitation/recreation camp for asthmatic children in Red House.

Dr. Elizabeth Uy Arceo, also of Charleston, was appointed Associate Medical Director.

Two of the speakers for the session on "Medical Potpourri" during the Eleventh Mid-Winter Clinical Conference held in Charleston in late January are shown (seated) in the left photo. They are Dr. Mary Lou Lewis and Robert H. Hoy, Pharm. D., both of Charleston. Talking to the speakers following the session are, from left, Drs. Ralph H. Boone, Sistersville; Silas C. Wiersma, St. Albans, and L. Dale Simmons, Clarksburg. On the right, Dr. Jean Neilson of Bluefield is shown with Dr. George E. Pickett of Charleston, Director of the West Virginia Department of Health, who was the speaker for the Saturday evening, January 28, dinner session.

Dr. Merle S. Scherr of Charleston, Foundation Medical Director since 1968, resigned from that position to remain as the volunteer Medical Director of the Bronco Junction Asthma Program.

The appointments of Doctors Skaggs and Arceo will allow for expanded use of the Bronco Junction facility by other organizations interested in conducting health- and education-related programs. Doctor Skaggs and Arceo will serve as liaison between these groups and the Foundation.

Any physicians in allergy, internal medicine, pediatrics, family practice or psychiatry who wish to serve for one or two weeks at Bronco Junction this summer should contact Doctor Scherr at 343-5427. Participants in the Volunteer Physicians Program at the camp are eligible for 50 hours of Category 1 credit toward the Physician's Recognition Award of the American Medical Association.

MU Receives Upjohn Grant

The Marshall University School of Medicine has been awarded $3,000 by the Upjohn Company, a pharmaceutical firm headquartered in Kalamazoo, Michigan.

Announcement of the gift was made recently by Dr. Robert W. Coon, Dean, and Dr. Bernard Queen, Eexcutive Director of the Marshall Foundation. The Foundation administers private funds contributed to the university.

The unrestricted grant will be used to assist in developing a psycho-pharmacology program within the School of Medicine which will be directed by Dr. Donald Robinson, head of the school's Pharmacology Department, according to Dean Coon.

"We expect to use this gift as seed money for the development of teaching and research programs in clinical psycho-pharmacology," Doctor Robinson said. "Our program will be developed in conjunction with the Departments of Psychiatry and Medicine and will benefit medical students, physicians-in-training, and community physicians."

One of the outgrowths anticipated is a mood disorders treatment program in conjunction with the Model Family Practice Center, Doctor Robinson added.

WVU Wheeling Division To Hold CME Program April 15

A continuing education conference, "Update on the Medical and Surgical Management of Biliary Tract Disease," will be held on Saturday, April 15, at the Ohio Valley Medical Center in Wheeling.

The conference is sponsored by the Wheeling Division of the West Virginia University School of Medicine.

The scientific program will begin at 8:05 A.M., with speakers and topics to include:

"History of Biliary Tract Surgery"—Bernard Zimmermann, M. D., Professor of Surgery, WVU School of Medicine, Morgantown; "Gallbladder Symptoms in Patients with 'Normal' Cholecysto-

Dr. Arthur C. Chandler, Jr., Durham, North Carolina, a native of Charleston, was a speaker for the session on "Medical Potpourri" during the Eleventh Mid-Winter Clinical Conference. In the left photo, he is shown (right) with, from left, Drs. William O. McMillan, Jr., a member of the Program Committee; Samuel A. Strickland and Pat A. Tuckwiller, all of Charleston. In the right photo, Dr. Maurice A. Mufson (left), Huntington, who presided at the session on "Medical Potpourri," is shown with Dr. Joseph T. Skaggs, Charleston, Co-Chairman of the Program Committee.

grams"—John E. Jesseph, M. D., Professor and Chairman, Department of Surgery, Indiana University School of Medicine; "Sodium Cholate in Retained Common Bile Duct Stones"—Abdolkarim Sohrabi, M. D., Chief Resident, Department of Surgery, Ohio Valley Medical Center;

"Problems in Acute Pancreatitis"—Daniel W. Elliott, M. D., Professor and Chairman, Department of Surgery, Wright State University, Dayton, Ohio; "Surgical Management of Bleeding Esophageal Varices"—Donald R. Cooper, M. D., Professor and Chairman of Surgery, Medical College of Pennsylvania; "Some Surgical Odditics in the Biliary Tract"—Doctor Jesseph;

"Management of Chronic Pancreatitis"—Doctor Elliott; "Complications of Biliary Tract Surgery and their Management"—Doctor Zimmermann, and "Newer Diagnostic Studies in Biliary and Pancreatic Disease"—Joseph N. Aceto, M. D., Chief, Department of Radiology, Ohio Valley Medical Center.

The conference will conclude following a panel discussion and question-and-answer period beginning at 3:45 P.M. Doctor Cooper will be the moderator.

The program meets the criteria for eight hours of Category 1 credit toward the American Medical Association Physician's Recognition Award, and is acceptable for eight Prescribed hours by the American Academy of Family Physicians.

The registration fee, which includes lunch, is $35 for physicians and $15 for graduate nurses, with no fee for residents, interns, medical students and student nurses.

For further information contact the Department of Continuing Education at (304) 234-8363, or 234-8827.

State Pediatric Chapter To Meet In Wheeling

The Spring Meeting of the West Virginia Chapter, American Academy of Pediatrics, will be held April 5 and 6 in Wheeling at the Wilson Lodge in Oglebay Park.

The meeting is co-sponsored by the Wheeling Division, West Virginia University School of Medicine.

The speakers and topics for the program on Wednesday, April 5, will include:

"Current Concepts and Management of Cystic Fibrosis"—Ruth Phillips, M. D., Associate Professor of Pediatrics, WVU, Morgantown; "Immunizations, 1978"—Henry Cramblett, M. D., Dean, College of Medicine, and Professor of Pediatrics and Medical Microbiology, Ohio State University; "Current Concepts in the Management of Juvenile Diabetes Mellitus"—Robert Benson, M. D., Director of Pediatric Endocrinology, Childrens Hospital of Akron (Ohio);

"Selection of Antibiotics"—Doctor Cramblett; "Hematologic Emergencies"—Paul Gaffney, M. D., Professor of Pediatrics, Childrens Hospital of Pittsburgh, and "Current Status of Hyaline Membrane Disease"—Leo Stern, M. D., Professor and Chairman of Pediatrics, Brown University.

Doctor Gaffney will deliver the banquet address Wednesday evening. His topic will be "Health Care in Britain."

The speakers and topics for Thursday will be "Bilirubin Metabolism"—Doctor Stern; "Evaluation and Initial Management of the Injured Child"—Thomas Morse, M. D., Associate Professor of Surgery, Ohio State University, and Director, Surgical Outpatient Unit, Columbus Children's Hospital; "Childhood Pneumonias"—Dennis Burech, M. D., Wheeling, Clinical Assistant Professor of Pediatrics, WVU; "Neonatal Intestinal Obstruction"—Doctor Morse, and "Evaluation of the Child with a Goiter"—Doctor Benson.

Dr. Robert Lewine of Wheeling is Chairman of the Program Committee.

Generic Substitution Measure Enacted By Legislature

The West Virginia Legislature concluded its regular 1978 session early in the morning of March 14 with enactment of a generic drug substitution measure the major piece of new health legislation.

State law has provided that there shall be no substitution, or the dispensing of a different drug in lieu of any drug listed in a prescription, without the approval of the physician or other practitioner authorizing the original prescription.

The new statute, to be effective July 1 and generally similar to laws in more than 30 other states, will mandate substitution of a generic drug for a brand drug name prescribed—*except that no substitution may be made by a pharmacist where the prescribing physician indicates that, in his or her professional judgment, a specific brand name drug is medically necessary for a particular patient.*

In other words, every drug prescription, written or oral, must contain an instruction from the practitioner as to whether or not an equivalent generic name drug or drug product may be sub-

stituted. The effect of this provision is to leave in clear language *with the physician* the continuing right to prescribe the medication he wants for the patient.

Contingent upon detailed review of the new statute as finally enacted, the State Medical Association will be providing in the near future more specific information on provisions of the new law—and will be clarifying, in particular, the format in which the prescribing physician may or may not authorize substitution.

International Automotive-Medical Meeting To Be Held In July

The American Association for Automotive Medicine, the largest group of physicians, engineers, and researchers in the nation who are interested in the medical aspects of automotive safety—along with the International Association for Accident and Traffic Medicine—will open a joint International Meeting on Automotive Medicine at the University of Michigan campus in Ann Arbor on Monday, July 10.

Continuing through noon on July 14, the scientific sessions will feature programs on the medical aspects of driver licensing, alcohol/drugs, automobile restraint systems, crash investigation, crash injuries, highway and vehicle design, motorcycle / bicycle / moped safety, pedestrian safety and emergency medical services. Julian A. Waller, M. D., Professor of Environmental Health and Epidemiology, University of Vermont, is Chairman of the program committee.

The meeting is open to all physicians, and to non-physicians who have an interest in automotive and highway safety. Registration and hotel information can be obtained from the AAAM Secretariat, P. O. Box 222, Morton Grove, Illinois 60053. Since attendance at some of the functions is limited, and to take advantage of an early registration discount, prompt response is recommended.

MEDICAL WRITING

Experienced medical writer with pharmacy degree will ghostwrite, rewrite, edit or proofread technical or general papers, articles, textbooks, handouts, educational materials etc. Local references available, fees mutually agreed before work commences. J. Marion Anderson, 90 School St., Morgantown WV 26505. Telephone 304-599-9319.

Medical Meetings

April 5-6—W. Va. Chapter, Am. Academy of Pediatrics, Wheeling.

April 7-9—W. Va. Chapter, AAFP, Charleston.

April 24-29—Am. Academy of Neurology, Los Angeles.

April 26-29—W. Va. Academy of Ophthal. & Otolaryn., White Sulphur Springs.

May 3-6—Am. Pediatric Surgical Assn., Hot Springs, Va.

May 3-6—W. Va. Chapter, ACS, White Sulphur Springs.

May 4-7—ASIM, San Francisco.

May 6—Air Pollution & Health Effects, Charleston.

May 8-12—Am. Psychiatric Assn., Atlanta.

May 10-12—Med. & Chirurgical Faculty of the State of Md., Hunt Valley, Md.

May 14-17—Am. Thoracic Society, Boston.

May 17-18—Advanced Cardiac Life Support Instructor Course, Morgantown.

May 21-25—Am. Urological Assn., Washington, D. C.

May 26-27—AMA Medical Staff Leadership Seminar, New York City.

June 10—W. Va. State Society of Anesthesiologists, Morgantown.

June 11-13—Am. Diabetes Assn., Boston.

June 11-15—Am. Society of Colon & Rectal Surgeons, San Diego.

June 17-22—AMA Annual Meeting, St. Louis.

Aug. 23-26—111th Annual Meeting, W. Va. State Medical Assn., White Sulphur Springs.

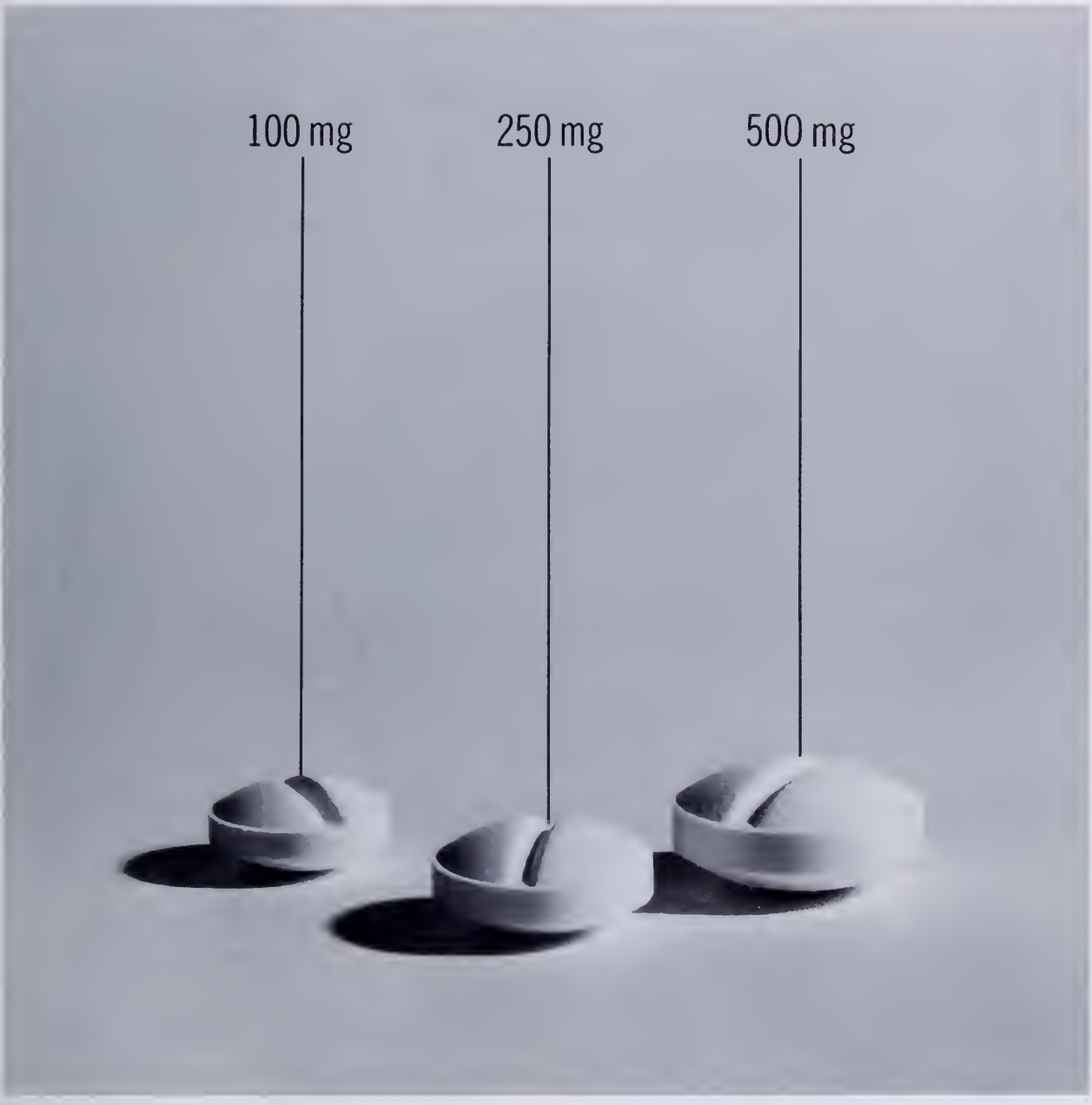
Sept. 10-14—Am. Academy of Ophthalmology & Otolaryngology (Otolaryngology Section), Las Vegas.

Sept. 25-28—AAFP, San Francisco.

Nov. 11-14—Southern Medical Assn., Atlanta.

1979

Jan. 26-28—12th Mid-Winter Clinical Conference, Charleston.



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WVU Medical Center
–News–

Compiled from material furnished by Mrs. Mary Ellin Wylie, Director, Medical Center News and Information Services, Morgantown, W. Va.

Myelomeningocele Clinic Serves 20 Children

William C. Hall II of Clarksburg is a handsome, bright child of three. Unlike other children his age, however, he has a handicap that he will have to cope with for the rest of his life.

Born with a myelomeningocele, a defect in his lower spine, "W. C." can stand and walk only with the help of a walker and short leg braces attached to orthopedic shoes.

W. C. was born March 1, 1975, in New Martinsville, where his parents were living at the time. Within eight hours of his birth he was brought to WVU Hospital where surgery was performed to close the spinal lesion and prevent the accumulation of spinal fluid in his brain.

He is one of about 20 children seen regularly in the Myelomeningocele Clinic of University Hospital's outpatient department. This service, staffed by physicians from four specialties, provides coordinated surgical and medical care for the variety of problems which plague W. C.

William C. Hall II of Clarksburg has his leg muscles checked by Dr. Robert N. Clark during a visit to the Myelomeningocele Clinic at West Virginia University Medical Center. With him is his mother, Mrs. W. Craig Hall.

The clinic, first of its kind in West Virginia, opened in March, 1974, with the cooperation and support of the Division of Crippled Children's Services in the West Virginia Department of Welfare. A similar clinic has since been established at the Charleston Area Medical Center.

The WVU clinic patients come not only from West Virginia but also from the neighboring states of Pennsylvania, Maryland and Ohio. Their care is coordinated among the pediatricians, orthopedic surgeons, urologists and neurosurgeons who comprise the staff.

In addition to the regular staff, consultants are available from other outpatient services such as the eye clinic and physical therapy. A genetic counselor serves as a consultant to those parents who, having had one affected child, are concerned about the possibility of bearing another child with the defect.

Medicine Faculty Members Present Papers

Three members of the Department of Medicine faculty returned recently from scientific meetings where they made presentations.

Dr. Rama Ganguly, Assistant Professor, and Dr. Robert H. Waldman, Professor and Chairman, were invited participants at the International Symposium on the Secretory Immune System and Caries Immunity held at the University of Alabama in Birmingham. Their papers concerned cell-mediated immunity in mucosal surfaces and studies on oral adjuvants.

Dr. Robert D'Alessandri, Instructor, presented a paper entitled "Streptococcal M-Protein Vaccine" on a program in Boston, Massachusetts, honoring Dr. Ed Kass. His co-authors included Dr. Ronica Kluge, Associate Professor and Chairwoman of the Division of Infectious Diseases, and Doctor Waldman.

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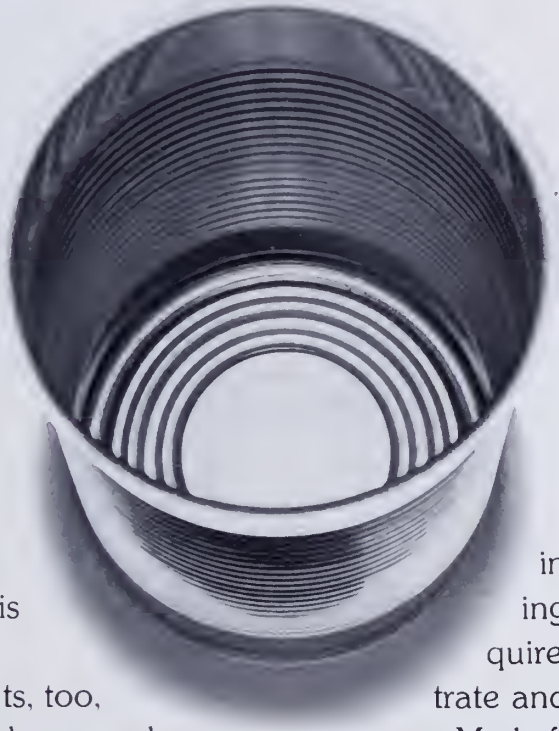

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Third-Party News, Views and Program Concerns

Final Rules For PSRO Review Under Medicare, Medicaid

The Health Care Financing Administration of the United States Department of Health, Education, and Welfare recently issued final regulations establishing procedures which conditional Professional Standards Review Organizations (PSROs) must follow to assume responsibilities for reviewing health services under the Medicare and Medicaid programs.

The rules are designed to help PSROs assure that services paid for by Medicare and Medicaid are medically necessary, appropriate and of acceptable quality, and to prevent duplication of review and certification activities.

The PSRO statute provides for three stages of PSRO development—planning, conditional and fully qualified. A PSRO is termed conditional before it demonstrates that it can perform all required review functions in hospitals and long-term-care institutions.

The regulations published February 22 in the *Federal Register* include four significant changes from proposed regulations published last January. The first three of the following changes reflect the provisions of the Medicare-Medicaid Anti-Fraud and Abuse Amendments that became Public Law 95-142 on October 25, 1977:

(1) A governor may comment when HEW is considering whether to designate an organization as a conditional PSRO and when a PSRO adds review of long-term and ambulatory care to its hospital-care review functions. The governor may also comment if he disagrees with HEW's opinion of a PSRO's capability to do its job.

(2) The PSRO must reach an agreement about its functions with state Medicaid agencies, state maternal and child health programs and with the insurance companies and plans which help operate Medicare. The requirement for this agreement may be waived by HEW under certain circumstances.

(3) The regulations provide that a PSRO may review care in intermediate-care facilities only if a state requests the PSRO to perform the review or if HEW finds that a state's review of those facilities is ineffective or inefficient. In the future, HEW will propose regulations defining effectiveness and efficiency. An intermediate-care facility is a Medicaid-certified, long-term-care institution that provides health-related services, but not the around-the-clock skilled nursing services required of skilled nursing facilities.

(4) Medicaid programs will pay claims for care given Medicaid patients in long-term-care institutions while a PSRO reconsiders its earlier disapproval of such care. For Medicaid patients, the PSRO appeals process replaces current state appeals procedures for determining issues of medical necessity.

The final regulations were effective February 22. However, the HCFA is encouraging public comment on the section of the final regulation that relates to Medicaid reimbursement during reconsideration because of the significance of the change.

Comments should be addressed to: Director, Office of Professional Standards Review Organization, Health Standards and Quality Bureau, HCFA, Room 16A-55, 5600 Fishers Lane, Rockville, Maryland 20857.

Comments will be received through April 22 and will be available for inspection at the same address between 8:30 A.M. and 5 P.M. Monday through Friday.

NCI Trying To Document Help Of Laetrile In Cancer

The cooperation of physicians was requested by the National Cancer Institute in March in the referral of cancer patients who appear to have benefited from the use of laetrile therapy. Records of these patients will be analyzed in an attempt to document anticancer responses to laetrile with or without "metabolic therapy" (the use of special diet, vitamins, enzymes and chelating agents). The NCI will use the data to decide whether controlled studies of laetrile therapy should be undertaken.

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Obituaries

GROVER C. MORRISON, M. D.

Word recently was received by *The Journal* of the death of Dr. Gover C. Morrison of Huntington on November 1, 1977. He was 92.

Doctor Morrison, who retired in 1975, was a former Cabell County coroner and had served as Chief Medical Adviser for the Cabell County Draft Board for 25 years.

Doctor Morrison also served as a school physician for two years and with the county health department for 10 years.

A native of Liverpool (Jackson County), he received his M. D. degree in 1913 from the University of Louisville School of Medicine.

Doctor Morrison was an honorary member of the Cabell County Medical Society, the West Virginia State Medical Association and the American Medical Association.

Survivors include the widow; two daughters, Mrs. Kitty Deegans and Mrs. Maurine Farrish, both of Huntington; two sisters, Mrs. Gay Patterson and Mrs. Hazel Smith, both of Akron, Ohio, and one brother, Cecil Morrison, also of Akron.

* * *

WELDON M. HARLOE, M. D.

Dr. Weldon M. Harloe of Princeton, formerly of Matoaka, died on January 25 in a Princeton Hospital. He was 70.

A native of Charlottesville, Virginia, Doctor Harloe was graduated from West Virginia University and received his M. D. degree in 1931 from the University of Virginia Medical School.

A veteran of World War II, he was a member of the Mercer County Medical Society, the West Virginia State Medical Association and the American Medical Association.

Survivors include two daughters, Mrs. Robert Davis of Lanham, Maryland, and Mrs. Ron Shetterley of Hayward, California; a son, William P. Harloe of San Antonio, Texas; a brother, Howard Harloe of Lakeland, Florida, and one sister, Mrs. Lucille Cupp of Richmond, Virginia.

* * *

ALEXANDER M. MacKAY, M. D.

Word has been received by *The Journal* of the death of Dr. Alexander M. MacKay of Forest Hills, Kentucky, formerly of Williamson, on December 15, 1977. He was 69.

(Continued on Page xvi)

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PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

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Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

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(Continued from Page xiv)

An anesthesiologist, Doctor MacKay was a former President of the Mingo Medical Society.

He was a native of New Glasgow, Nova Scotia, Canada, and received his M. D. degree in 1933 from the Dalhousie University Faculty of Medicine in Halifax, Nova Scotia. He interned at Victoria General Hospital in Halifax, later completing postgraduate work at Oxford University in England and the University of Wisconsin.

Doctor MacKay, who served with the Canadian Army Medical Corps during World War II, was a Diplomate of the American Board of Anesthesiology, certified by the Royal College of Surgeons, Canada, and was a Fellow of the Faculty, Anesthesiology, Royal College of Surgeons, England.

He was located in Redwood City, California, from 1952 to 1958.

Doctor MacKay was a member of the Mingo Medical Society, the West Virginia State Medical Association and the American Medical Association.

Survivors include the widow.

* * *

CLAUDE FRAZIER, M. D.

Dr. Claude Frazier of Huntington died on February 9 in a Lexington, Kentucky, hospital. He was 85.

Doctor Frazier also had practiced at Montgomery and Ansted and several other locations in Fayette County.

A native of Knoxville, Tennessee, he received his M. D. degree in 1916 from the University of Tennessee College of Medicine in Memphis.

Doctor Frazier was an honorary member of the Cabell County Medical Society, the West Virginia State Medical Association and the American Medical Association.

Survivors include the widow; two sons, Dr. Claude A. Frazier of Asheville, North Carolina, and Dr. Calvin Frazier of La Canada, California; a daughter, Mrs. James G. Henderson of Lexington, and two brothers, Dr. Ralph Frazier of Beckley and Judge Alfred Frazier of Knoxville.

* * *

H. R. W. VIAL, M. D.

Dr. H. R. W. Vial of Charleston died on March 2 in a hospital there. He was 66.

Doctor Vial had practiced in South Charleston for 30 years, and was a member of the staff of Herbert J. Thomas Memorial Hospital there.

He received his M. D. degree in 1943 from the Medical College of Virginia, and interned at Charleston General Hospital.

A veteran of World War II, Doctor Vial was a member of the Kanawha Medical Society, the West Virginia State Medical Association, American Medical Association, the American Academy of Family Physicians, and the American Occupational Medicine Association.

Survivors include two sons, H. R. W. Vial, Jr., of Evansville, Indiana, and John C. Vial of York, Pennsylvania, and three daughters, Mrs. Dorothy Meyer of Los Angeles, Mrs. Betsy Hoben of Manchester, New Hampshire, and Mrs. Nancy Cagle of South Charleston.

* * *

LLOYD E. COX, M. D.

Dr. Lloyd E. Cox, retired Charleston pediatrician, died on March 5 in a hospital there after a long illness. He was 88.

A native of Gary (McDowell County), he formerly was located at Mohawk (McDowell) and Hardy, Kentucky.

Doctor Cox was a former Secretary of the McDowell County Medical Society and a Past President and Vice President of the Pike County (Kentucky) Medical Society.

He was graduated from Marshall University and received his M. D. degree in 1923 from the University of Louisville (Kentucky). He served his internship and residency at hospitals in Louisville and did postgraduate work at Harvard University and in New York City.

Doctor Cox, who retired in 1970, was an honorary member of the Kanawha Medical Society, the West Virginia State Medical Association and the American Medical Association.

Survivors include the widow; three daughters, Mrs. Ann Ovington and Mrs. Barbara C. Mason, both of Charleston, and Mrs. Phyllis Cline of Atlanta, Georgia; a sister, Mrs. Alma Perry of Largo, Florida, and a brother, Gay W. Cox of Silverton (Jackson County).

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County Societies

CABELL

The Cabell County Medical Society met on February 9 at the Gateway Inn in Barboursville.

The speaker was Dr. Maurice A. Mufson, Chairman of the Department of Medicine at Marshall University School of Medince. Doctor Mufson spoke on newer problems with vaccines, with special emphasis on viral vaccines.

Dr. John F. Otto, Jr., discussed the West Virginia Health Systems Agency, and called for physicians to increase their influence on health planning. Doctor Otto is a member of the Region II Health Planning Advisory Board of the HSA. —James R. Cook, M. D., Secretary.

* * *

MERCER

The Mercer County Medical Society held a joint meeting with the Mercer County Bar on February 20 at Frankie's La Salute Club in Princeton.

Following a social hour and dinner, a short period followed in which members of the two societies exchanged comments in an informal way.—David F. Bell, Jr., M. D., Secretary.

* * *

McDOWELL

The McDowell County Medical Society met on February 8 at the Stevens Clinic Hospital in Welch.

Dr. Bernard M. Swope, Chairman of the Program Committee, presented the scientific program. He discussed laetrile and the various claims and theories of its proponents as an anticancer agent.—Muthusami Kuppusami, M. D., Secretary.

* * *

MONONGALIA

The Monongalia County Medical Society met on February 7 at the Old Mill Club in Morgantown.

The scientific program was presented by Dr. Richard Lindsay, whose topic was "Political Atmosphere in West Virginia."

Dr. Ronica Kluge discussed the project she is undertaking for the evaluation of Russian influenza vaccine.

Dr. Robert N. Clark discussed the facility which the Easter Seal Society is interested in building for handicapped children adjacent to the new school which will be built in Morgantown.—Barbara Jones, M. D., Secretary.

Book Review

HANDBOOK OF POISONING, 9TH EDITION—Robert H. Dreisbach, M. D., Ph. D. Lange Medical Publications, Los Altos, California 94022. 559 Pages. 1977. Price $8.

Despite the presence of poison control centers, many people call the hospital emergency department, physicians' offices or pharmacies when a poisoning occurs. Therefore, physicians, nurses, and pharmacists often look for a simple, single source of information to handle poisoning emergencies. I recommend *Handbook of Poisoning* as the best reference book for a non-poison-center situation.

Doctor Dreisbach divides his book into six (6) parts: general considerations, agricultural poisons, industrial hazards, household hazards, medicinal poisons, and animal and plant hazards. Each part covers the characteristics and the management of the broad category and describes the more common examples.

The ninth edition has been expanded and updated from the eighth edition of 1974. There are 40 more pages. Each chapter has literature references which are current. The older references have been dropped. Certain sections have been revised to conform to current thinking regarding management. Examples are the management of snake bites and hydrocarbon ingestions. Discussion of poisons which were not prevalent in 1974 has been added. Examples are the management of poisoning from phencyclidine and acetaminophen. The information about mushrooms has been rewritten.

I believe this book fulfills well its purpose to provide a concise summary of the diagnosis and treatment of clinically important poisons. It has been improved since its last edition; therefore, I recommend that everyone get the newer edition.—Willard F. Daniels, Jr., M. D.

AMA Has New Committee on Services to Young Physicians

The AMA now has an Ad Hoc Committee on Services to Young Physicians. Objectives of the 11-member group are to determine the needs of young practicing physicians in order to recommend the modification of existing AMA activities and creation of new services.

Answers To Review Article Questions

(Questions on Page 77)

1. a. 5 to 10 per cent.

2. e. none of the above.

3. d. all of the above.

4. d. The low MHPG group showed either no mood change or became more depressed during a trial with dextroamphetamine (Dexedrine).

5. a. acute onset.

6. e. b and c above.

7. c. positive family history for psychiatric illness.

8. d. all of the above.

9. e. 150 mg. per day for at least three weeks.

10. c. supportive and even rehabilitative psychotherapy may be necessary in addition to antidepressant medication.

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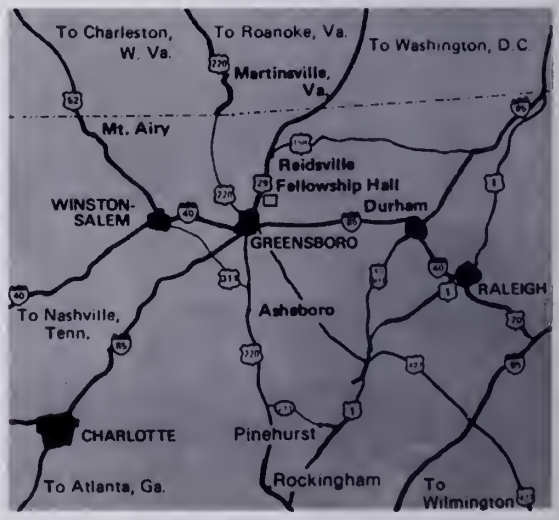

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The West Virginia Medical Journal

Vol. 74, No. 5 May, 1978

Meningococcal Infections: Sixteen Years' Experience

TIMOTHY G. SAXE, M. D.
First-Year Resident, Internal Medicine, Charleston Area Medical Center.

ROGER G. FINCH, M. D.
Assistant Professor of Medicine, Division of Infectious Diseases, West Virginia University School of Medicine, Morgantown.

A review of meningococcal infections at West Virginia University Hospital from 1961 to 1976 stresses the nonspecific nature of clinical features prior to the onset of the typical purpuric rash, which remains the key to diagnosis. Our experience is consistent with other published studies. The mortality was high (24 per cent) and sequelae were frequent. The information presented further emphasizes the need for early recognition and prompt treatment, as well as the need for a polyvalent vaccine for control of meningococcal infections.

The meningococcus remains a continuing threat to life and health. Its behavior is enigmatic and unpredictable: a high percentage of the population carries it without harm, but then quite suddenly an isolated episode of infection occurs or a serious epidemic is produced. Such was the experience in Brazil in 1974 when, during the months of July and August, 13,141 cases of meningitis were admitted to a hospital in Sao Paulo.

Case Presentation

A four-month-old, white male, who was full term at birth and had a normal delivery, was admitted to West Virginia University Hospital with a 12-hour history of fever, vomiting, tachycardia, and a rash of three hours' duration.

On admission he was cyanosed, crying weakly and clinically dehydrated. The rash was purpuric and present over the extremities, head, shoulders, and back, sparing the abdomen and chest. During the physical examination, the rash visibly progressed with coalescence of the purpuric lesions. The flush blood pressure was 40 mmHg; heart rate was 208 beats per minute; and the femoral pulses were weak. There was no nuchal rigidity. The chest was clear and the abdomen soft with no hepatosplenomegaly. He was generally hypotonic with poor pain response, but the reflexes were equal and normal and the plantars were flexor. Brudzinski's sign was positive.

A lumbar puncture was performed for culture and analysis in addition to two sets of blood cultures and a throat swab. A Gram stain of the purpuric lesions showed scanty Gram-negative intracellular diplococci. The hemoglobin was 12.1 g/100 ml. with a white cell count of 7.6 x 10^3/dl. Cerebrospinal fluid revealed a glucose of 43 mg/dl with a simultaneous serum glucose of 66 mg/dl, protein 30 mg/dl, 14 red cells/cc, and seven white cells/cc, which included one granulocyte and six lymphocytes.

Immediate management included intravenous fluids, oxygen, ampicillin 150 mgs/kg/ day IV, and gentamicin five mgs/kg/day IV. There was transient improvement, but then he deteriorated progressively. Disseminated intravascular coagulation was suspected and the possibility of Waterhouse-Friderichsen syndrome considered. Shortly after the administration of 250 mgs. hydrocorti-

TABLE 1

Summary of Cases: West Virginia University Hospital, 1961-1976

	Cases			Deaths	
	Male	*Female*	*Total*	*Male*	*Female*
Birth - 12 months	2	3	5	1	0
13 months - 6 years	3	1	4	1	0
> 6 years - 15 years	1	3	4	0	2
> 15 years	2	2	4	0	0
TOTALS	8	9	17	2	2

TABLE 2

Presenting Signs and Symptoms of Meningococcal Infection

	All Ages	*< 6 years*	*> 6 years*
Fever > 38.3°C	16 (94%)	8 (89%)	8 (100%)
Meningismus	13 (76%)	7 (78%)	6 (75%)
Nausea or vomiting	12 (71%)	6 (67%)	6 (75%)
Rash	8 (47%)	5 (56%)	3 (38%)
Headache	7 (41%)	.....	6 (75%)
Tachycardia	7 (41%)	5 (56%)	2 (25%)
Altered consciousness	6 (35%)	.....	5 (63%)
Coryza-like symptoms	4 (24%)	4 (44%)	.....
Seizures	2 (12%)	1 (11%)	1 (13%)
Time of initial onset of symptoms to admission	32 hours	40 hours	21 hours
TOTALS	17	9	8

sone hemisuccinate, he became apneic and died within six hours of admission. Autopsy was not performed. *Neisseria meningitidis* was isolated from the blood and throat while the spinal fluid grew no organisms.

Meningococcal Infections at WVU, 1961-1976

In the past 16 years, there have been 17 patients with meningococcal infection admitted to West Virginia University Hospital. These are summarized in Table 1. The age range was from 45 days to 27 years with 30 per cent of our cases below one year of age. Fifty-three per cent of the cases and 50 per cent of the mortalities fell in the preschool age group of six years or younger. Four of our cases—three of whom died—exhibited a rapidly progressive course. In addition, there was one other death from complications.

The presenting features of these 17 cases are shown in Table 2. In our series, the rash was noted at the time of presentation in 47 per cent and, in the remaining 53 per cent, the rash developed after initial evaluation.

Laboratory values are summarized in Table 3. Two patients in whom IgA immunoglobulin levels were estimated showed reduced levels. In our series, 37 per cent had sequelae. These included two patients with seizures requiring long-term anticonvulsive therapy. Two had herpetic lesions, including one with a severe recurrence of herpetic keratitis. There was one case of cerebral death following eradication of infection.

Disseminated intravascular coagulation was confirmed by coagulation studies in four patients. of whom three died. There was no autopsy information to determine the incidence of Waterhouse-Friderichsen syndrome.

TABLE 3

Laboratory Values on Admission

					Cerebrospinal Fluid Findings		
Age	*Sex*	*White Blood Cell Count*	*Platelets*	*White Cell Count/cc*	*Granulocytes (%)*	*Glucose (mg%) csf/plasma*	*Protein (mg%)*
1½ mos.	F	19,200	adequate	8,000	88%	8/102	175
4½ mos.	F	18,200	adequate	22,000	97%	6/110	123
5 mos.	F	10,700	adequate	12,100	98%	21/140	420
6 mos.	M	17,700	adequate	4	0%	76/148	28
2 yr	F	7,300	adequate	1,920	99%	128/148	470
2 yr	M	17,500	adequate	4	0%	90/.....	19
5 yr	M	15,200	adequate	4	0%	71/103	15
*5 yr	M	8,800	adequate	4,700	89%	10/.....	380
6 yr	M	1,900	low	2,560	97%	15/183	280
14 yr	F	34,600	adequate	25,100	99%	15/250	375
17 yr	F	27,200	adequate	17,000	93%	15/235	535
24 yr	F	20,100	adequate	7,300	93%	20/140	245
27 yr	M	9,300	low	135	18%	45/100	94
Fulminant Cases By Three of Five Prognostic Criteria							
*4½ mos.	M	7,600	adequate	7	14%	43/66	30
*10 yr	F	16,200	41,000	25	84%	90/133	34
*12 yr	F	17,700	adequate	50	64%	35/115	500
19 yr	M	8,700	low	11	100%	17/116	94

*Died

Discussion

In our experience, early symptoms of meningococcal disease commonly include fever, nausea, vomiting, cough, coryza-like symptoms and lethargy. Of the features listed in Table 2, the presence of rash, meningismus, tachycardia and headache showed an age-related distribution. In those under six, rash and tachycardia were more commonly present on admission than were meningismus or headache. In the over-six group, evidence of cerebral irritation was present in all but one. Although less common, the neurologic abnormalities were more severe in the under-six age group, with two presenting with a seizure disorder.

All patients developed the rash of meningococcal septicemia, although it was only present on admission in 47 per cent. The rash is typical and distributed initially on the limbs, evolving centrally, with mucosal involvement being a common feature. The rash begins as fine roseolar papules on the limbs, which rapidly develop into petechial or purpuric spots. As the rash moves centrally the lesions coalesce to produce ecchymoses with deep button-like indurations under the original purpuric spots. The speed of progression in fulminant cases is quite startling, taking less than four hours to become generalized, justifying the description purpura fulminans. Aspiration and culture of material from the purpuric lesions were positive in 83 per cent of cases with negative systemic blood cultures.[1] A Gram stain of this material will show intracellular, Gram-negative diplococci. Recent studies have suggested this to be a Schwartzman reaction mediated by a capsular lipopolysaccharide.[1,2,3]

Complications of meningococcal infections are frequent and diverse. The most dramatic and frequently fatal is the Waterhouse-Friderichsen syndrome, which is usually an autopsy finding of severe adrenal infarction. Disseminated intravascular coagulation and the Schwartzman phenomenon may explain the vascular problems which include the rash which may involve the skin and mucous membranes, producing hemorrhagic necrosis sometimes requiring skin grafting. Cardiac involvement can produce dysrhythmias, pericarditis, myocarditis and acute left ventricular failure. Neurological complications including seizures and peripheral neuropathy have been reported in seven per cent of cases in one series of military recruits.[4] Herpetic infections are common[1] and particularly troublesome if they involve the eye, as seen in our one case.

Arthritis of the larger joints in meningococcal disease may take either of two forms, and is probably the most common sequela.[4,5,6] Arthritis developing within the first 24 hours is usually septic, as compared with the later development of a polyarthritis as part of a serum sickness-like syndrome.[4] There is good evidence relating the severity and incidence of complications to the levels of circulating meningococcal lipopolysaccharide antigens.[6,7,8,9]

Immunity has been shown to correlate well with the circulating bacterial antibody, which develops following nasopharyngeal carriage.[7,10,11,12] Vaccine-protected populations have good resistance to type specific strains with fewer nasopharyngeal carriers, thus leading to a lower attack rate.[12] The relationship between asymptomatic carriage and attack rate is important since, when the carriage rate increases, individuals who lack circulating antibody to the type specific antigen have an increased risk of severe infection.[12]

Of interest is our finding that in two cases, serum IgA levels were below normal. To our knowledge, this has not been reported before.

To determine the prognosis of individual cases, Steihm and Damrosch[13] studied the following: (1) Petechiae of less than 12 hours' duration prior to admission, (2) Hypotension (less than 70 mmHg systolic), (3) Less than 20 white blood cells/cc cerebrospinal fluid, (4) White blood cell count less than 10,000/cc, and (5) Erythrocyte sedimentation rate less than 10 mm/hr (Westergren).

In their original series of 63 patients, the presence of three prognostic factors correlated well with fulminant disease and had an 85.7 per cent mortality in the first 48 hours, while those with four or five factors had 100 per cent mortality. Other series using identical criteria have produced similar results.[7,13] Our series showed 75 per cent mortality in patients with three prognostic factors and the death of one patient with two factors present.

Acknowledgements

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Endobronchial Carcinosarcoma*

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A case of endobronchial carcinosarcoma treated successfully by lobectomy is reported with a review of the literature in an attempt to identify the preferable method of operative management.

PULMONARY carcinosarcoma is a rare primary lung tumor which characteristically presents in two distinct clinical variants based on its anatomic location: (1) an endobronchial lesion producing symptoms of obstruction, cough, hemoptysis, distal pneumonitis, bronchiectasis, and atelectasis, or (2) as a more peripheral, parenchymal lesion predisposing to malaise, weight-loss, and other subtle clinical signs and sequelae. The endobronchial form typically displays slow growth with local invasion and metastases usually occurring late. Although life-threatening respiratory obstruction can result early, these features often predict a favorable response to surgical treatment. However, the more peripheral lesion is frequently recognized only after extensive spread has occurred.

Case Report

A 38-year-old, Caucasian female was noted to have a left upper lobe radiodensity on a routine chest x-ray in May of 1974. The review of systems was entirely noncontributory. The patient had an approximate 15 pack-years smoking history, but had been a non-smoker for the preceding five years. The physical examination was entirely unremarkable.

Tomography of the lesion revealed a soft tissue mass without cavitation in the left upper lobe. Flexible fiberoptic bronchoscopy confirmed an endobronchial tumor in the apical-posterior segmental orifice. Multiple biopsy attempts were unsuccessful, and washings were negative for cytopathology. On June 12, 1974, thoracotomy and left upper lobectomy were accomplished without complication. The resected specimen revealed a yellowish-white endobronchial neoplasm (Figures 1a and 1b) which demonstrated both spindle and epidermoid cell types. Dual histopathologic examination of the specimen by the Armed Forces Institute of Pathology and the University of California at San Diego established the diagnosis of endobronchial carcinosarcoma. The patient is alive and asymptomatic without evident disease 35 months following resection.

Discussion

Histologically, pulmonary carcinosarcoma consists of a carcinomatous parenchyma within a sarcomatous stroma,[5] and metastases may be carcinoma, sarcoma, or carcinosarcoma.[1,3] The intermingling carcinoma and sarcoma elements are distinct from "collision tumors" which result from the chance association of a carcinoma and a sarcoma arising independently, but in close proximity. Some authors[5] have suggested that an epidermoid carcinoma may be the primary neo-

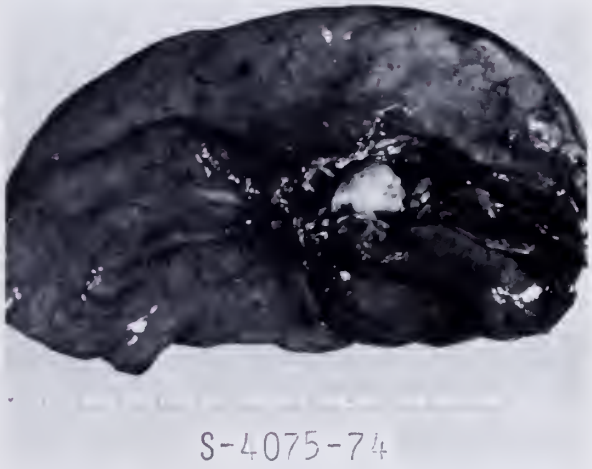

Figure 1a. Left upper lobe with proximal endobronchial lesion.

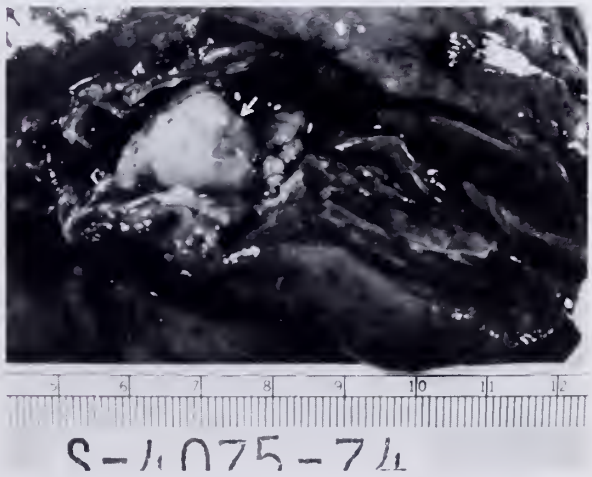

Figure 1b. Close-up view showing tumor within left upper lobe bronchus (white arrow).

*This paper was written while Doctor James was Associate Professor of Surgery, West Virginia University Medical Center, Morgantown.

plasm with the sarcomatous component merely representing a connective tissue response. Others have interpreted the spindle cells as deformed or misshaped epidermoid cells with intercellular edema or swelling resulting in cell dispersion with the obliteration of any apparent intercellular bridging.[12] However, Bergmann,[1] Spencer[12] and other contributors[8,10,13,14] accept carcinosarcoma as a distinct histopathologic entity and review the clinical and experimental evidence. Perusal of the literature reveals 46 additional cases with an acceptable diagnosis of pulmonary carcinosarcoma, although Stackhouse[13] considers Peabody's case[9] a pulmonary blastoma variant of carcinosarcoma. The majority of the carcinomas have been epidermoid, but alveolar and adenocarcinoma cell types have been reported. Sarcomas have been mostly spindle-cell fibrosarcoma, with chondrosarcoma, leiomyosarcoma, and osteogenic sarcoma forms occasionally identified.

Typically, endobronchial carcinosarcoma hosts a much better prognosis than its peripheral counterpart because of the obstructive symptomatology which may develop.[6,15] The cases reviewed indicate hilar lymph nodes are infrequently involved unless the tumor extends extrabronchially. Inasmuch as the patient with an endobronchial lesion may seek early consultation, localization of the tumor can still be difficult. Rigid bronchoscopy may fail to identify the tumor, or upon visualization, provide a negative biopsy.[6,7,14] Kakos[6] utilized bronchography to demonstrate a left mainstem bronchus lesion not identified at bronchoscopy. Kern[7] reported a patient with cough, hemoptysis, and recurrent expectoration of tumor fragments over a period of one year before localization was accomplished. In our patient, flexible, fiberoptic bronchoscopy easily identified the tumor within the left upper lobe.

The surgical treatment of pulmonary carcinosarcoma may be curative or palliative. Peripheral tumors associated with fever, pain, weight loss, or fatigue often predict palliative treatment only. Bergmann[1] reported the first two successful resections for endobronchial carcinosarcoma, both pneumonectomies. Moore[8] reported the first successful lobectomy for an endobronchial lesion and observed that the anatomic origin of the pedunculated tumor often made lobectomy preferable to pneumonectomy.

An analysis of the patients who have undergone resection for pulmonary carcinosarcoma (Table) confirms the opinion of several authors[1,6,8,11,14,15] that the endobronchial tumor manifests a relatively favorable prognosis with prompt surgical management. Twenty endobronchial tumors were considered potentially curable by resection, although hilar node involvement or extrabronchial spread was apparent in at least seven of these cases. Eight of the nine survivors were among the 13 patients who did not demonstrate gross hilar extension of their tumors. In lesions with limited local invasion, both pneumonectomy and lobectomy produced similar survival rates. The reported follow-up periods varied from six months to six years. Although on occasion the quality of life was temporarily improved, none of the peripheral or advanced extrabronchial neoplasms was successfully resected for cure.

Summary

Pulmonary carcinosarcoma is a rare, primary lung neoplasm with the prognosis and operative treatment somewhat related to the anatomic location of the tumor. Usually, it is identified as either (1) an endobronchial growth with symptoms of obstruction, i.e., cough, hemoptysis, distal pneumonitis, bronchiectasis, and atelectasis, or (2) a solid peripheral lesion which achieves considerable size and spread prior to recognition.

The diagnosis can be difficult with negative rigid bronchoscopy, biopsy, and cytology even with the primary endobronchial location. Flex-

TABLE

Results of Surgical Resection in 28 Patients with Pulmonary Carcinosarcoma

	Lobectomy			Pneumonectomy		
Location	*No. of Cases*	*Survivors*	*Per Cent Survival*	*No. of Cases*	*Survivors*	*Per Cent Survival*
Endobronchial	6*	4	66.7	8	5**	62.5
Extrabronchial	4	0	0	2	0	0
Peripheral	7	0	0	1	0	0
TOTAL	17	4	23.5	11	5	45.5

*Includes our patient.

**One patient reported alive at 18 months with metastatic nodules in resected specimen.

ible, fiberoptic bronchoscopy and bronchography are helpful in the evaluation of possible obstructing lesions. Our experience with a case of endobronchial carcinosarcoma successfully managed by lobectomy is presented. In addition, the operative treatment of 27 other cases of pulmonary carcinosarcoma in the literature is summarized. Conservative surgical resection is indicated whenever possible.

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The greatest glory of a freeborn people is to transmit that freedom to their children.

—William Harvard

Mountaineer Personality Roots

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Mountain personality roots are important concepts for the Appalachian doctor to grasp. This paper explores roots from three vantage points: genealogical, linguistic, and personality. The traits of pride, anger, envy, greed, sloth, gluttony, and lust are defined. With an understanding of these concepts, physician empathy leading to better management will be enhanced. The presentation emphasizes both the humorous and serious sides of personality formulations and doctor-patient relationships.

LANGUAGE and constructs used in medicine, and especially psychiatry, obscure a dimension of clinical competence beyond technological considerations. This dimension is commonly termed the "art of medicine." The components of practicing the art of medicine in Appalachia are explored in this paper in terms of the Mountaineer's genealogical, linguistic and personality roots. Empathy by the physician is encouraged. As a matter of prognosis, some futuristic and utopian medical thinkers feel the physician may already be in danger of becoming obsolete in favor of computors, automated laboratories, and sonor diagnostic devices. The critically important role left for the human physician will be the management of patients and their health problems. With understanding and empathy in mind, addressing "you all" as doctors for the folk of Appalachia, I make a personal bid for going beyond treating disease, going beyond the iatrotrophic stimulus that brought the person to you (that is, going beyond treating the chief complaint as if that were the whole problem).

Getting back to the "art" or wisdom of medicine will mean understanding the Mountaineer and his personality roots. His thinking includes such concepts as *pride, anger, envy, greed, sloth, gluttony* and *lust*. These will be defined.

Chief Complaints

Mountaineers are "plain spoken" folk. We who are native to the West Virginia hills have a heritage of a dialect that is masculine, robust, and virile. Our medical history-gathering, particularly for psychiatry, abounds with a colorful phraseology that appears to be genetic-born into the bones of ourselves as well as our patients. Where else could one get chief complaints such as these:

1. "No, the baby didn't come early, the weddin' come late!"
2. "That man is so contrary, if you throwed him in a river he'd float upstream!"
3. "She walks so slow that they have to set stakes to see if she's a-movin'!"
4. "That lad's an awkward size—too big for a man and not big enough for a horse!"
5. "That pore boy's so crosseyed he could stand in the middle of the week and see both Sundays!"
6. "He's so drunk he couldn't hit the ground with his hat!"
7. "She looks like she's been chewed up and spit out!"
8. "He looks like he's been a-sortin' wildcats!"
9. "He looks like the hind quarters of hard luck!"
10. "She looks like somethin' the cat drug in that the dog wouldn't eat!"

Genealogical Roots

In the style of Alex Haley, who spent 12 years compiling and creating *Roots, the Saga of an American Family*, I'd like to acknowledge the first "furriner" to West Virginia, the Scotch-Irish Mountaineer, because the basic culture of Appalachia is Celtic. The people who came to America from Ulster were Scotch-Irish (who were really Scotch).

As Alex Haley[1] speaks of the Griots of Africa from whence his roots came, we can rightly say of our typical Mountaineer that "it is as if a library has burned to the ground" when a Mountaineer dies. The Mountaineers "symbolize how all human ancestry goes back to some place, some time, where there was no writing. Then, the memories and the mouths of ancient elders [were] the only [ways] that early histories of mankind got passed along . . . for all of us today to know who we are."[1]

Early in his English reign, James I decided to try to control the Irish by putting a Protestant population into Ireland. To do this he confiscated the lands of the earls of Ulster and bestowed them upon Scottish and English lords on the condition that they settle the territory with tenants from Scotland and England. This was

known as the "Great Settlement," or the "King's Plantation," and was begun in 1610.

While in Ulster the Scots multiplied, but after roughly 100 years they became dissatisfied with the unreasonable trade and religious restrictions imposed by England, and numbers of them began emigrating to the English colonies in America. The first wave came into New England, but thereafter many of these Scots who now called themselves the "Scotch-Irish" came into Pennsylvania where, finding the better lands already settled by the English, they began to move south and west. Their enterprise and pioneering spirit made them the most important element among the vigorous frontiersmen who opened up this part of the South and later other territories further west into which they pushed. Daniel Boone is a prime example of these folk.

Besides the Scots who arrived from Ireland, more came directly from Scotland to America, particularly after "the '45," the final Jacobite uprising in support of "Bonnie Prince Charlie," the Young Pretender, which ended disastrously for the Scottish clans that supported him. By the time of the American Revolution, there were about 200,000 Scots in this country.

Linguistic Roots

Most of the eventual Appalachian "root people," the Scots, moved into Ulster from the lowlands, and thus they would have spoken the Scottish variety of the North Umbrian or Northern English dialect. (Most highland Scots at that time still spoke Gaelic.)

The Scottish influence on Appalachian local speech prevails. Raven I. McDavid, linguistic authority, notes, "The speech of the hill people is quite different from both dialects of the Southern lowlands for it is basically derived from the Scotch-Irish of western Pennsylvania."[2] H. L. Mencken, another linguistic authority, said of Appalachian folk speech, "The persons who speak it undiluted are often called by the southern publicists 'the purest Anglo-Saxons in the United States,' but less romantic ethnologists described them as predominantly Celtic in blood, though there has been a large infiltration of English and even German strains."[2]

The reason our people still speak as they do is that when these early Scots and English and Germans (and some Irish and Welsh, too) came into the Appalachian area and settled, they virtually isolated themselves from the mainstream of the American life for generations to come because of the hills and mountains, keeping the old speech forms that have long since fallen out of fashion elsewhere.[3]

Personality Roots

With this brief genealogical and linguistic overview, consider now our personality roots.

Characteristically, the Mountaineer is not a person to be pushed where he does not wish to go nor is he submissively responsive to a shaping process. The Mountaineer, like his ancestors, has always chosen to live in isolated areas reflecting and reinforcing the characteristics of an independent, free, self-reliant people to whom family solidarity and traditionalism were a way of life. Resignation to factors beyond his control has, in the past, stimulated the Mountaineer to turn to God for resolution of his circumstances.

The seemingly contradictory traits are the suspiciousness of and yet friendliness toward strangers. A person who comes into the neighborhood with authority is resented; if, however, he is on a level with and does not "talk down" to people, he meets with warm hospitality.

Quick fighting, love of race, distrust of government, servility to no man, a taste for politics, pessimism, action-seekers who do not like routine, animal raisers and hunters—these are the characteristics of the mountain people. They are contemplative, real people who have kept many of the basic human qualities that make for a rich person-oriented culture. This person-orientedness may well be the aim of a civilization once the age of cybernation passes and frees man to find "the wisdom of a balance between making a living and making a life."[3]

With this background, consider a "here and now" situation: A mountaineer family arrives in the doctor's office. A family spokesman states: "I've been a-studyin' about how to say this, 'til I've nigh wearied myself to death. I reckon hi't don't never do nobody no good to beat about the bush, so I'll just tell ye. Our man's hippoed. There's nothin' ails him, but he spends more time using around the doctor's office than he does a-workin."[3]

If the doctor were listening closely he has just diagnosed from that family that the patient is a hypochondriac.

How will he effectively manage this Mountaineer?

Empathy has long been touted as the *sine qua non* of clinical practice. The capacity to use one's own feelings to experience vicariously what the patient feels is a highly refined skill that the wise physician uses as adroitly as digitalis or delicate surgery. With the Mountaineer, the first important principle is that management grows out of an appropriate relationship between doctor

and patient. In general terms, Peabody, in 1927, set the tone, "The treatment of a disease may be entirely impersonal: the care of a patient must be completely personal . . . for the secret of the care of a patient is in caring for the patient.[4] Elaborating on this theme, Richards wrote, "But once a physician does take upon himself the responsibility for a patient's care, instantly he becomes a different man . . . suffering, moreover, is different from misfortune: it comes not in battalions, but by one and one. Each man's is his own."[5] Houston added an important reminder, ". . . the doctor's attitude toward the patient is perhaps more fundamental than the patient's attitude toward the doctor . . . the faith that heals is not through argument but by contagion."[6] Finally, Fox specified the therapeutic attitude, "But if the physician is so good a doctor as not to be put off by weakness, folly, grief or sin, or even bad manners . . . the relationship can be something invaluable."[7]

The consensus of these writers is that the physician's use of self in management is the critical ingredient. The proper use of self is far more technical and specific than simply good bedside manners or exhibiting common courtesy. It involves elements that must be learned and has goals that are as specific as any pharmacopoeia.[8]

With the Mountaineer's genealogical roots clear; his linguistic roots clear; and his personality roots emerging, let's elucidate the personality traits.

Today, psychiatrists have criteria established for basic personalities:

a. Obsessive compulsives
b. Hysterical
c. Paranoid
d. Passive-aggressive
e. Sociopathic

Any psychiatrist and, for that matter, most clinicians can easily talk of the "core" dynamic conflict in each type and predict the issues and behaviors that must be negotiated in order to establish a therapeutic relationship with each type. But now lay aside our concepts and consider the Mountaineer patient's concepts or roots.

'Seven Deadly Sins'

The final part of this paper is an investigation of an ancient list of personality formulations known as "The Seven Deadly Sins" to all who recall the rather humorous song from *Camelot*. As described by early church fathers, these traits are similar to syndromes described in our *Diagnostic and Statistical Manual II of Psychiatry*.

From the 12th century on, seven traits are found in confessor's manuals, and many an author, including Dante, Chaucer, and Gower, utilized them in literature. Scottish and, subsequently, mountaineer artists, preachers, and storytellers found them a source of material. It is my contention that the current Mountaineer still thinks in terms of these "seven sins" because of his roots.

To physicians, our mountaineer family might put it this way: "Spare your all selves a sight of grief when a body comes in plum out of his head and the family is all fire and tow after having the breadwinner take a backseat."

"Let on" that you understand what is happening and you will be more easily trusted and not seen as a "furriner." Simply put, to have his trust, shouldn't a doctor know the Mountaineer's language? After all, it is foolish to buy a "pig in a poke."

Here, then, is a brief description of each of the seven sins as collected from the writings of the church fathers and current commentators.[9]

Pride is the radex or root of the root sins. It is the original sin, the wish to be like God. As described by the sources, it is a tendency to want more than most people to occupy first place; to occupy positions of authority over others; to be impatient with authority and external restraints; to overestimate one's own gifts and ability; to be blind to good qualities in others; perhaps to show contempt for others; to be anxious to get credit for achievements; to tend to presumptuous ambition; undertaking tasks one hasn't the ability to perform; to thrive on praise and recognition; perhaps to boast or to depreciate one's self excessively; to be shocked by the faults of others but satisfied with self; to be strongly opinionated and inflexible; and to chafe under God's rule. Pride, more than any of the other traits, involves reality distortion about one's place in the universe.

Anger is a tendency to display more than most people a strong desire for revenge; to harbor resentment; to figure ways to get even; to argue, quarrel, or fight; to go around silent and sullen; to use sarcastic, cynical, or insulting language; to be indignant and critical; to wish to harm others, or "to even the score." The fathers are careful to point out that anger is not *per se* sinful, and that there is a difference between the emotion of anger (taking just, loving, punitive action) and the trait as described above.

Envy is a tendency greater than that of most people to be unhappy when someone else "gets

a break." It is a unique sin among the seven because it alone *promises no rewards to the sinner.* It is well described as "sorrow for another's good." It is distinguished from jealousy in that it is pointless, while jealousy seeks, sometimes legitimately, to protect what is one's own. Even God is jealous, but never envious. Envy is a tendency to be secretly or openly glad when someone else has trouble; to suffer loss of self-esteem when someone else obviously has more than one's self; to be especially eager to expose any defects one sees in others; to try, if possible, to interpret the words or deeds of others *as bad;* and to be constantly comparing one's self and one's qualities, possessions, or achievements with others'.

Greed or avarice is a tendency greater than that of most people to want to accumulate material things just for the sake of possessing them; to be willing to cheat, lie or steal to gain or retain material possessions; to be "tight-fisted" with money, excessively thrifty, over-cautious about spending; to be stingy rather than giving; to be callous toward those in need; to find it very painful to pay debts or to avoid repayment wherever possible; to be excessively distressed even at small losses; and to have difficulty trusting God in His promise to provide one's needs.

Sloth is a tendency greater than that of most people to want to avoid expenditure of effort on important matters; to have the feeling that prayer or attentive worship is too much trouble; to be tired and sluggish when confronted with work; to feel that one's will is especially weak and that therefore it is useless to try to break bad habits; to procrastinate; to invest oneself in trivial activities; to look for bodily ease and comfort; to prefer idleness to activity; to feel sad much of the time; to be deeply angry with oneself; to drift along in mediocrity; and to be dissatisfied with God when He does not give one feelings of ease, peace and consolation.

Gluttony is a tendency greater than that of most people to want to indulge one's appetites, physical, intellectual, or aesthetic; to eat too much; to eat too fast; to be preoccupied with food; to be preoccupied with drinking; to drink too much or too often; or to be especially choosy or particular about food or drink; to be preoccupied with the desire for fine, especially well-prepared, or gourmet food; to be so preoccupied with enjoyment of the aesthetic qualities of literature, music, or art that God is obscured or duties are neglected. The hedonist or Kierkegaard's aesthetic man is a perfect example of the glutton.

Finally, *lust* is a tendency greater than that of most people to be preoccupied with pleasure related to sex; to think about sex, to the exclusion of other things; to focus one's attention on looking at, touching, embracing, or physical union with love objects to the point where God is obscured or other important matters are neglected; to be excessively interested in conversation or jokes about sex; to be nearly dominated by love of sensuous pleasures.

Summary

Hopefully, in summary, the clinically-wise physician will know that it is not enough to determine what condition the patient has, but also what patient has the condition.

The Appalachian doctor, to summarize differently, should not be like the specialist who feels his patients have what he treats, but rather he should be like the generalist who treats what his patients have. Accurate personality assessment has relevance for all aspects of the clinical situation and enables the physician to make a number of informed decisions about management and to predict important characteristics of the developing doctor-patient relationship. In Appalachia, the formulations might be better made in ancient terms of *pride, anger, envy, greed, sloth, gluttony* and *lust.*

Finally, to leave one last impression regarding the very *roots* of the concept of the "Seven Deadly Sins," let me quote a well-known national personality, "Before we become too arrogant with the most deadly of the seven deadly sins, the sin of pride, let us remember that the two great wars of the century, wars which cost twenty million dead, were fought between Christian nations praying to the same God."—Richard M. Nixon.

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Medical Grand Rounds

From the West Virginia University Hospital

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Legionnaires' Disease

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Legionnaires' disease is now established as a disease entity which has the ability to produce sporadic illness and epidemic disease. The severity of the illness ranges from mild to fulminating. Pre-existing disease and increasing age are associated with a poor prognosis.

Epidemiologic studies have shown that it is not confined to North America, although the actual source of the bacillus remains unknown. The wider availability of simplified diagnostic tests would greatly assist in the diagnosis of epidemics and individual cases, while increased awareness of the disease will hopefully lead to better therapeutic regimens and thus reduce mortality.

It is a rare event in medicine for a new disease to be described, and it is rarer still for such a disease to have a major impact upon the medical profession and the public at large. Legionnaires' disease accomplished this and generated clinical, epidemiologic and laboratory investigation, directed toward understanding the disease.

Initially, our appreciation of the disease was the result of investigations of "epidemic" Legionnaires' disease. Sporadic cases have subsequently been recognized as have other epidemics, many of which have been diagnosed retrospectively by serologic methods.

Epidemic Legionnaires' Disease

Epidemic Legionnaires' disease occurred in July and August, 1976, in Philadelphia, following the 58th Annual Convention of the American Legion and the 56th Annual Convention of the American Legion Auxiliary, Department of Pennsylvania, held at the Bellevue-Stratford Hotel from July 21-24, 1976.[1] Although not confined to Legionnaires or their families attending the convention, attack rates were highest for these persons, being 6.8 per cent and 6.3 per cent respectively. Illness was not associated with residence at any hotel other than the Bellevue-Stratford.

Of the 182 persons finally confirmed as suffering from Legionnaires' disease, 149 attended this convention. The remaining 33 persons included one hotel employee, 20 persons unconnected with any convention and 12 persons who attended one of three other conventions held in July and August: a Magicians' Convention (1), a Candlemakers' Convention (2), and a Eucharistic Congress (9).

Although the epidemic was soon recognized, it took several weeks before its full extent was finally appreciated. To confuse the investigators, several cases of pneumonia with similar clinical features occurred during the same period of time in persons neither attending the convention nor staying at the Bellevue-Stratford Hotel.[1] This was dubbed *Broad Street Pneumonia* after the street of that name in Philadelphia.

For the purposes of defining Legionnaires' disease a case had to meet both epidemiologic and clinical criteria. The epidemiologic criteria required the patient to have attended the American Legion Convention or to have entered the Bellevue-Stratford Hotel between July 1 and the onset of illness. The clinical definition was that of an illness characterized by cough and fever >38.9°C,

or any fever and radiographic evidence of pneumonia, between July 1 and August 18, 1976. Similarly, the definition of *Broad Street Pneumonia* required meeting the same clinical criteria, but the epidemiologic requirement was presence within one block of the Bellevue-Stratford Hotel between July 1 and the onset of illness.

Several epidemiologic surveys conducted collaboratively by the Center for Disease Control and the Pennsylvania Department of Health were aimed at case identification.[1] The surveys included telephoning guests who had stayed at the convention hotel as well as other hotels in Philadelphia, interviewing employees at the Bellevue-Stratford Hotel, monitoring hospital admissions and emergency room records at three city hospitals, checking records of reported influenza and pneumonia deaths, and contacting the local commander of each of the 1,002 local American Legion posts in Pennsylvania to determine the number of persons attending the convention, and to distribute a questionnaire to those individuals.

Included in the epidemiologic investigation was a detailed appraisal of food, alcoholic and non-alcoholic beverages ingested, time spent in specific areas of the hotel, as well as time spent outside the hotel and a record of places visited. Smoking habits were analyzed, contact with animals and fomites noted and the possibility of airborne or person-to-person transmission investigated.

These surveys showed that illness was associated with residence in the Bellevue-Stratford. In particular, Legionnaires who became ill spent more time in the lobby and on the sidewalk in front of the hotel than did controls. There was no evidence to suggest person-to-person spread or transmission by food, beverages or inanimate objects. The risk of disease was greater in cigarette smokers than non-smokers, although no particular brand could be incriminated. The incubation period was found to be five to six days, but ranged from two to 10 days. However, in two persons the incubation periods were 16 and 26 days, respectively.

Of the 182 persons who became ill, 75 per cent were 40 to 69 years old, but their ages ranged from three to 82. The male-to-female ratio was 3.5:1. Eighty-one per cent were hospitalized and 16 per cent died.

The criteria for *Broad Street Pneumonia* were met in 39 patients, of whom 24 were males. The ages of these patients ranged from 19 to 70, with a mean of 50.6 years. Five of these persons died.

Clinical Illness

The disease was remarkable for its rapid onset and severity; milder forms did occur, but these were uncommon. Pre-existing illness was present in approximately one-half of those attacked; chronic pulmonary disease, hypertension, arteriosclerotic cardiovascular disease, peptic ulcer disease and malignancy were noted most frequently.

At the onset of the disease, malaise, myalgia and headache predominated, and were followed by a rapid rise in temperature, shaking chills and a non-productive cough.[1] The fever frequently rose to 38.9°C to 40.6°C and was hectic in 22 per cent and remittent in 62 per cent. Chest pain was common and pleuritic in one third. Dyspnea, abdominal pain and gastrointestinal symptoms, including hemorrhage, were also frequently present. However, the major clinical findings were related to the chest. The dry cough frequently became productive over the course of two days, but was rarely blood-stained or purulent. A progressive pneumonitis with scattered rales, but without consolidation was usual. Respiratory failure occurred in 20 per cent and was a major cause of death. In 50 per cent, death was preceded by a state of clinical shock. The illness lasted approximately seven days when either clinical resolution occurred or the patient died from respiratory failure or shock.

Laboratory investigations showed a white blood cell count ranging from 8000-15000; 50 per cent of patients had a shift to the left with more than five per cent band forms. Urinalysis indicated that 20 per cent had >3+ proteinuria on admission and 10 per cent microscopic hematuria. Minor elevations of liver enzymes were found in one third of patients. A few patients had electrolyte changes compatible with the syndrome of inappropriate secretion of ADH. Mild elevation of the BUN and serum creatinine was not unusual, while acute renal failure requiring renal dialysis occurred in a few patients.

The chest radiograph showed multilobar infiltrates in 90 per cent of those x-rayed, and had either an alveolar or interstitial appearance. In 50 per cent, the findings were unilateral. Effusions were rarely seen. Radiographic resolution tended to lag behind clinical resolution by a few days.

Sputum obtained by expectoration or transtracheal aspiration was scanty and nonpurulent except in those patients who developed secondary infections or had chronic bronchitis. The Gram-stained appearance showed a remarkable lack of polymorphonuclear cells and scanty bac-

teria compatible with normal oropharyngeal flora, unless secondary infection had intervened.

A wide range of antibiotics was used, but no single agent was curative. However, an analysis of the case-fatality rates showed erythromycin and tetracycline to be associated with the lowest rates, while cephalothin (Keflin) and gentamicin (Garamycin) had the highest rates.

At autopsy, the lungs were the only organs to show changes consistently. There was a diffuse interstitial pneumonia with alveolar damage in the affected segments. The bacillus of Legionnaires' disease was demonstrated in the lung, using the silver Dieterle method.[2] This is a spirochetal stain which stains the organism a brown to black color. The concentration of the bacillus was greatest in the alveoli and respiratory bronchioles of affected areas, but minimal in the alveolar septa, larger bronchioles or bronchi. The organisms were visible both intracellularly and extracellularly. The paucity of organisms in the large airways supported the finding that the bacillus was not commonly demonstrable in the sputum.

Differential Diagnosis

There are relatively few respiratory diseases that have the epidemic characteristics of Legionnaires' disease. However, in the differential diagnosis the viral pneumonias figure prominently, most notably influenza. The non-purulent nature of the sputum is unlike many bacterial pneumonias, although infection by *Mycoplasma pneumoniae* should always be considered; the severity of the illness, the older patient and lack of circulating cold agglutinins are differentiating clues which need to be confirmed by serology. Ornithosis is another possibility and an exposure history should be pursued.

Laboratory Investigations

The laboratory investigations to identify the cause of Legionnaire's disease were far reaching and of multidisciplinary nature.[3] The agents considered included toxins, bacteria, chlamydiae, fungi, mycoplasmas, parasites, rickettsiae and viruses. The contemporaneous national interest in swine influenza led to the rapid exclusion of this as an etiologic possibility. Food-related or water-borne agents were similarly undetected. Nickel carbonyl, found in small quantities in the ventilation system of the hotel and in trace amounts in autopsy samples, received considerable publicity, but was later excluded.

Several weeks after the epidemic, the first evidence to indicate an infective agent was forthcoming. Adult male guinea pigs were injected intraperitoneally with one ml of a 10 per cent suspension, in Bovarniks sucrose-phosphate-glutamate buffer, of lung tissue from a fatal case. In the guinea pigs, an illness characterized by fever, watery eyes and prostration developed within one to two days, followed by death in three to six days. Smears of the guinea pig liver and spleen obtained on the second day and stained by Gimenez method showed bacilli to be present.[3]

The next observation followed the inoculation into the yolk sacs of six- to seven-day-old embryonated hens' eggs of spleen, liver and lung tissue suspensions from the affected guinea pigs. The embryos died in four to seven days and Gimenez staining of the yolk sac showed the characteristic pleomorphic bacilli. These were 2-4 μm long and 0.3 to 0.4 μm wide.[2] Occasional bacilli were from 8 to 20 μm long. Electron microscopy showed the structure to resemble that of a Gram-negative rod.

Subsequently, it was found that Mueller-Hinton agar supplemented with one per cent hemoglobin and two per cent Isovitalex (BBL) would support the growth of the bacterium at 35°C in an atmosphere of five per cent carbon dioxide.[3] It has also been reported to grow on commercially available chocolate blood agar (Gibco).[4]

By fixing the bacterium from the hen's yolk sac to a glass slide, an indirect fluorescent antibody test was developed. This permitted the serological evaluation of suspected cases and also provided an investigative tool for epidemiologic studies. *Seropositivity* was defined as a titer $\geqslant$128 and *seroconversion* as a four-fold rise in titer to $\geqslant$64. Of the 111 epidemic cases analyzed, 56 per cent showed seroconversion while 35 per cent were seropositive. Antibody titers were detectable usually from the second to third week of illness and peaked around the fifth week, subsequently decreasing over the following months.[3]

Other Epidemics

Using the indirect fluorescent antibody test, a number of "mystery" epidemics that have occurred in the past have now been shown, by serologic testing, to be compatible with Legionnaires' disease.

In 1965, 81 patients in a psychiatric hospital in the District of Columbia developed an illness clinically similar to Legionnaires' disease; 12 patients died. Twenty-one of 23 patients, from whom paired sera had been stored, had titers showing seroconversion or seropositivity.[3]

In 1968, 144 personnel and visitors to the county health department in Pontiac, Michigan,

suffered a mysterious illness characterized by sudden onset of fever, chills and myalgia, but without pneumonia; no deaths resulted. Again from stored sera, 31 showed seroconversion and one, seropositivity.[3]

Of greater interest was the finding that, in 1973, 164 persons in a party of British vacationers traveling to Benidorm, Spain, became ill: 80 had a respiratory illness and three died. Stored serum again suggested that the illness was compatible with Legionnaires' disease.

Following the outbreak in Philadelphia, a number of sporadic cases of Legionnaires' disease has been confirmed from 30 states and the District of Columbia. In addition, clusters of infection have occurred in a number of hospitals. For instance, in a Vermont hospital, 17 of a suspected 32 cases died.[5] This high mortality may have been related to the fact that many of the patients had malignancies or were renal transplant recipients, or undergoing chronic renal dialysis.[6] Renal transplant patients were also involved in a California hospital.[7] In Kingsport, Tennessee, four hospitals reported 25 cases with three deaths.[5]

A total of 150 sporadic cases has been confirmed, with 32 deaths (21 per cent).[5] This compares with a 16 per cent mortality rate for the Philadelphia outbreak. Other reports have confirmed that sporadic cases have not been restricted to the United States.[8,9]

Speculation as to the origin and epidemiology of the bacillus remains unconfirmed. However, some of the institutional outbreaks have been associated with soil excavations in the vicinity. This would support the evidence that the disease is transmitted by the air-borne route. The apparent absence of person-to-person spread suggests the reservoir of infection is other than man in whom infection is opportunistic in nature. Soil, rodents and birds are under investigation as potential sources of the bacillus.[1]

Antibiotic Therapy

Laboratory testing has shown the bacillus to be sensitive to a wide range of antibiotics.[4] The minimum inhibitory concentration to penicillin and ampicillin is 1 μg/ml. It is relatively resistant to the cephalosporins. *In vitro*, rifampin is the most active agent, requiring <0.25 μg/ml to inhibit growth. Gentamicin (Garamycin), although appearing effective from *in vitro* sensitivity testing, had a case-fatality rate of 36 per cent when used for epidemic Legionnaires' disease, and is not recommended.

The currently recommended antibiotic is erythromycin. The basis for this is a case-fatality rate of 10 per cent among patients with epidemic Legionnaires' disease treated with erythromycin[1] and *in vitro* sensitivity data.[4] In addition, studies in male guinea pigs challenged with a lethal intraperitoneal dose of the bacillus have shown erythromycin and rifampin to be effective in preventing death when compared with an untreated control group.[10] These studies also suggest that the two drugs possess additive or synergistic effects.

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A message from . . .

The President

SUMMER LULL LONG GONE

LIKE the five-cent cigar, the summer lull for those wrestling with legislative and related health care issues is no more. There may be the usual hot-weather recess in meetings of specialty and other medical groups, but this is the wrong time for general relaxation.

Recent movement of major bills by Congressional subcommittees confirmed what we already knew. The Carter Administration, desperately in need of a major so-called domestic legislative triumph, is exerting the strongest kind of pressure for a "short-term," mandatory nine-per cent cap on hospital revenue increases and a limit on capital expenditures.

Analyses of the bills emerging from House subcommittees in Washington indicate a big push toward cost containment with no practical concern for such things as quality of care. One bill ignores voluntary efforts pledged by state and national medical and hospital associations—and others—to reduce hospital costs in a measured and reasonable fashion. The other proposal undermines such an effort. In fact, such officials as HEW Undersecretary Hale Champion flatly say the voluntary effort won't work. It would help if HEW would at least give the effort a chance.

At the state level, the Board of the West Virginia Health Systems Agency, Inc., is moving toward approval of a Health Systems Plan. The Medical Association and others have asked the HSA to seek more time to revise the plan, and further review of it lies ahead at various levels, but a deep concern remains. Are we going to have grass roots-based health planning in West Virginia for ALL West Virginians; or are we headed toward a new maze of restrictive, federally-mandated rules and regulations that hold little promise of good for anyone? Some "planners" say we, at best, will have some of both.

There's no simple answer to complex issues such as these, but a suggestion or two should be considered. Stay on top of what's going on around you. Make a special effort, as physicians and citizens, to alert your patients and the public to all this tinkering. And most important—stay awake!

JOSEPH A. SMITH, M. D., *President*

The West Virginia Medical Journal

Editorials

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MAJOR REVISION URGED FOR STATE HSA PLAN

In an unprecedented move, the State Medical Association has joined forces with two other major organizations of health care providers to express deep concern about a Health Systems Plan being developed for West Virginia by the Health Systems Agency, Inc. Because of the critical nature of the problem at hand, and the far-reaching, long-range impact the plan will have on the citizens of this state, the *Journal* is devoting space normally reserved for editorial comment to offer the following detailed statement and comments addressed to the HSA:

This is a joint response of the West Virginia Hospital Association, the West Virginia Medical Institute and the West Virginia State Medical Association to the West Virginia State Health Systems Plan and Annual Implementation Plan. This response is designed to meet the April 3, 1978, deadline.

BASED UPON EVALUATION OF THE RECENTLY TRANSMITTED HEALTH SYSTEMS PLAN FOR WEST VIRGINIA, WE EXPRESS STRONG CONCERN ABOUT THE CREDIBILITY AND QUALITY OF THE DOCUMENT.

Our concerns are related to three levels of the plan as follows:

(1) The process used in developing the Health Systems Plan;
(2) the structure of the Health Systems Plan document; and
(3) the content of the Health Systems Plan itself.

THE PLANNING PROCESS APPEARS TO BE SLANTED MORE TOWARD NATIONAL TIMETABLES AND DIRECTIONS THAN TO THE NEEDS OF WEST VIRGINIA CITIZENS.

We see some of the important process problems as:

- The plan was developed under an unreasonable time schedule;
- the State Health Coordinating Council has neither been in place nor operating for the last two years;
- sensitivity to local and rural health issues has not been reflected; and
- local consumer and provider involvement, as called for in the law, has not been adequately emphasized or met.

THE HEALTH SYSTEMS PLAN DOCUMENT IS STRUCTURED IN A MANNER THAT IS NEITHER LOGICAL NOR UNDERSTANDABLE TO THE AVERAGE CITIZEN.

Three of the important deficiencies in the structure of the Health Systems Plan document are:

- The use of language and words that are both inappropriate and difficult to understand;
- it is not logically constructed and does not contain sufficient information so that it can be implemented; and
- the difficulty of distinction between guidelines and policies of the Health Systems Agency within the body of the plan itself.

THE HEALTH SYSTEMS PLAN DOCUMENT HAS QUESTIONABLE CONTENT THAT WAS USED FOR THE DEVELOPMENT AND SUPPORT OF CONCLUSIONS.

- The plan is not sensitive to West Virginia in certain areas, such as the rural and aged:
- the formulae and assumptions used under the data content tend to destroy the credibility of the plan.

Details which address our concerns in the areas above are expanded upon in the attached schedule.

In summary, we advocate the development of a plan that is understood and supported by consumers and providers. A plan should be a statement of intent on the part of the people who have and/or control the resources needed for implementation. If those with the resources are not deeply involved in the plan development or do

not understand the plan as developed, failure or confrontation will result. There is and has been a strong interest on the part of providers to participate in developing the plan and its recommendations.

We strongly recommend that the West Virginia Health Systems Agency request that the Department of Health, Education and Welfare (DHEW) grant an extension of time to review and revise the current plan. The undersigned pledge full support to such a request by the Health Systems Agency. When granted, we suggest that, within approximately 30 days, another series of hearing dates be established. With additional time the revision of the plan, using a methodology with strong consumer and provider input, can address these and other concerns. Such a major restructuring and editing will develop a Health Systems Plan that is useful and understandable. The plan would be one we all can be proud of and support.

We are fully aware of the pressures on the Health Systems Agency by DHEW to finalize the Health Systems Plan. This unrealistic time schedule has had the effect of creating many communication and review problems.

Each of the signing organizations is working extremely hard on the development of clear and specific recommendations. These comments will be submitted as a follow-up to this letter at a later date.

It is our sincere belief that approval of the Health Systems Plan in its current form would be a tragic disservice to the citizens of West Virginia.

SCHEDULE EXPANDING UPON COMMENTS

I. *Planning Process Concerns*

A. Too much emphasis is placed on the federal and state point of view with little emphasis on local input. Public Law 93-641 was specifically designed and intended for local planning.

1. In nearly every instance, the time allowed between receipt of draft plan components and meeting dates was entirely too short for proper review.
2. The volume of printed matter was too great to review and analyze in the short time allotted.
3. The volume of material and short lead time seemed to affect adversely the attendance at meetings of local committees (RHAC and task forces) and also their ability to perform proper analysis. At times a quorum was not present and there was insufficient time in the schedule to reconvene the committees.
4. Given the limited time schedule, there was no opportunity for drafting, commenting on and redrafting cycles of the components.

B. It does not appear that the draft HSP will properly bring together health systems planning guidelines into one document. The "rules of the game" should be spelled out in one specific section. For example, objective DT1-1, page 5, Section II, Chapter 4 of the plan provides for specific bed needs; however, on the following five to six pages the document addresses guidelines for the State Medical Facility Plan.

C. Involvement of health care providers has been in the latter stages of the planning process.

1. Providers were not consulted initially regarding the planning approach, methods and data.
2. Providers were only involved in review of completed draft sections of the plan prepared primarily by HSA staff.
3. There was no opportunity, except in a very limited sense, to discuss, suggest, offer ideas, express philosophies or make other comments necessary to the "give and take" ingredient of effective planning.

D. The planning process places greater emphasis on national guidelines and issues than on the unique problems of West Virginia.

1. The inappropriate incorporation of national guidelines "in toto" covering:
   a. Pediatric inpatient services
   b. Open heart surgery
   c. Cardiac catheterization
   d. Radition therapy
   e. End-Stage renal disease.
2. There is a lack of sensitivity throughout almost all sections of the plan regarding the needs of rural and elderly residents:
   a. Use of local hospitals where confidence and need have been previously expressed and exhibited by residents.
   b. There is insufficient consideration to the consequences of modification and/or relocation of the existing delivery system, such as the effect on quality, accessibility and distribution of health manpower.

E. The planning process itself does not follow a logical sequence—nor does it employ generally accepted planning methods.

1. Specifications (guidelines, standards and criteria) are not clearly defined.
2. There is no inventory of existing health care resources.
3. There is little discussion or evaluation of utilization of existing facilities.
4. There is no inclusion or recognition of services for the elderly provided by state hospitals.
5. Analyses and projections of future needs are addressed only in rare instances.
6. The plan begins with conclusions and lacks a sufficient degree of specific recommendations to achieve such conclusions.
7. There appears to be an inadvertent conflict between consumers and providers on one hand and HSA staff and the federal position on the other.

SUGGESTION: Establish a new cycle for plan development. Use the present draft for discussion and developmental purposes, allowing sufficient time for study, debate, redraft and review. The plan needs specific procedures for the receipt and consideration of amendments from interested persons.

II. *Plan Structure Concept*

A. The plan is not written so that it can be easily understood by consumers and providers because of:

1. Too much "boilerplate" and bureaucratic jargon.
2. Use of complex formulae without sufficient explanatory detail and without enumerating assumptions used under the formulae.
3. Fragmentation of inpatient services throughout the plan.
4. Summary level information appearing at the beginning of the plan, but substantiating details to support the summary are difficult to find.

B. A lack in the plan of sufficient information to allow providers to carry out their individual planning efforts.

1. No delineation of planning guidelines.
2. It is difficult, if not impossible, to separate clearly HSA policy from:
   a. National study information
   b. Analysis methodology
   c. Opinions
   d. Estimates
   e. Personal philosophy.

C. Combining the HSP with the AIP is extremely awkward. It is most difficult to separate the two plans. The AIP should be a separate and distinct section of the plan.

SUGGESTION: The plan needs extensive restructuring if it is to become a useful and meaningful tool.

III. *Plan Content Concerns*

A. There are major problems within the content of the HSP that reflect upon the credibility of the Board of Directors of the HSA and its planning process.

1. While emphasizing population-based planning, the plan itself does not forecast or offer specifics on major groupings of population:
   a. Pediatrics — Age 0 to 14
   b. Adults — Age 15 to 64
   c. Elderly — Age 65 and over
   d. Women (childbearing) — Age 15 to 44
2. There is no recognition of an increasing female and elderly population which will require future modification to the delivery system.

B. The eleven planning areas do not reflect true medical service areas and patient referral patterns.

1. There is insufficient consideration given to patient flow intrastate and interstate.
2. There is insufficient consideration given to patient flow based on type of treatment needed: tertiary, intermediate and primary.
3. There is no documented justification for utilizing the eleven planning areas.
4. The plan does not address the coordination of service areas.

C. The plan does not consider the direct and indirect economic impact on the various areas of West Virginia:

1. Cost to the consumer
2. Cost to the provider
3. Cost to the taxpayers
4. Employment patterns
5. Local economics
6. Unique industrial circumstances.

D. There is a lack of understanding of the role of hospitals and other providers in the or-

ganization and delivery of services for rural West Virginia areas:

1. Inpatient facilities:

   a. Methodology is not sensitive to rural health needs. There is no explanation of the assumptions used in the formulae. It is difficult for providers to understand. We also question the Board's understanding of the formulae and subsequent impact of the formulae on quality and accessibility:

      (1) West Virginia has 9,740 beds.

      (2) By 1983, using the present 73 per cent occupancy level, West Virginia would need 11,181 beds.

      (3) The plan formula states that by 1983 West Virginia would need 8,602 beds *but* this would be at a *95 per cent* occupancy rate.

      (4) The National Planning Guidelines only call for 80 per cent occupancy. Using an 80 per cent occupancy level we show a need for 10,213 beds.

      (5) Using the plan formula, rural hospitals would be required to have the following occupancy rates:

         (a) 50-bed facility—88 per cent occupied

         (b) 100-bed facility—91 per cent occupied

         (c) 200-bed facility—93 per cent occupied

      (6) The plan does not address waiting time for admission under the above quoted occupancy rates.

      (7) The plan does not address occupancy rates by distinct services, i.e., obstetrics, pediatrics and adult beds, which are not universally available.

   b. Based on the preceding, objectives regarding acute hospital bed requirements far exceed federal guidelines and reasonable limits. In fact, 80 per cent occupancy level under federal guidelines was intended to be adjusted downward for rural facilities.

2. The plan's treatment of obstetrics destroys the broad continuity of family-oriented practice, resulting in:

   a. Problems with accessibility.

   b. Endangering approved teaching programs.

   c. A disturbance of family practice. This could cause a loss of pediatricians, obstetricians and gynecologists in rural communities. It also may cause a loss of those family practitioners whose practice includes obstetrics.

   d. The "domino" effect of losing local physicians would have a serious impact on the health and welfare of citizens.

D. The plan is generally silent in the area of manpower needs, especially in the rural areas.

1. The plan does not contain sufficient information on the use of physician and nurse extenders and other para-professionals.

2. The plan does not offer a means to seek solutions to the current shortage of health professionals.

GENERAL NEWS

Iowa Medical College Dean To Address Convention

Dr. John W. Eckstein. Dean of the College of Medicine at the University of Iowa in Iowa City, will speak during the 111th Annual Meeting of the West Virginia State Medical Association August 23-26 at the Greenbrier in White Sulphur Springs.

John W. Eckstein, M. D.

Doctor Eckstein, whose topic will be "An Overview of Hypertension," is scheduled for the first scientific session on Thursday morning, August 24, it was announced by Dr. David B. Gray of Charleston, Chairman of the Program Committee. The first session will be a "Symposium on New Developments in Treatment of Common Disorders."

Doctor Eckstein is President Elect of the American Heart Association, and will succeed to the Presidency at the Association's 1978 annual meeting next November.

A noted scientific investigator, medical teacher, and administrator. Doctor Eckstein was aided early in his research career when the Heart Association awarded him financial support for his work during 1954. As a scientist of promise in 1958. he was appointed by the Association to a five-year term as an Established Investigator to assure continuity of support for his work. He received a Research Career Award from the National Institutes of Health in 1963.

Doctor Eckstein is known for his research on factors affecting the control of the peripheral circulation in health and in such clinical conditions as hypertension and heart failure.

A native of Central City, Iowa, and son of a physician. he earned a B. S. degree in Mathematics from Loras College in Dubuque and an M. D. degree in 1950 from the University of Iowa College of Medicine.

He completed his internship at Letterman General Hospital in San Francisco in 1951 and his residency in internal medicine at University of Iowa Hospitals in 1953.

Dean Since 1970

Doctor Eckstein has served on the staff of the Department of Internal Medicine, The University of Iowa College of Medicine, since 1953, becoming Professor of Internal Medicine in 1965 and Dean of the College of Medicine in 1970.

As a volunteer leader of the Heart Association, he has been active in national programs for more than 20 years. In 1969, he was named Vice-President and Chairman of the Committee of Regional Vice-Presidents. He also was Chairman of the Great Plains Regional Research Advisory Committee.

The recipient of the Award of Merit of the Heart Association, he was a member of its Board of Directors for six years, and served on the Committee on Research Planning and Policy, the Committee on Future Organization and Structure, and the Budget and Finance Committee.

Doctor Eckstein was elected President of the Iowa Heart Association in 1965. He served as President of the Central Society for Clinical Research in 1973-74 and as Chairman of the Midwestern Section of the American Federation for Clinical Research in 1965.

He is a Fellow of both the American College of Physicians and the American College of Chest Physicians. He has been elected to membership in a number of scientific societies including the American Physiological Society, the American Society for Pharmacology and Experimental Therapeutics, the American Clinical and Climatological Association, the American Society for Clinical Investigation, and the Association of American Physicians. He is active in the affairs of the American Medical Association and the Association of American Medical Colleges.

From 1968 to 1972, he was a member of the Cardiovascular A Study Section of the National Institutes of Health, serving as Chairman from 1970 to 1972. In September, 1977, he completed

a three-year term on the National Heart, Lung, and Blood Institute Advisory Council.

Doctor Eckstein lives in Iowa City with his wife, Jean. They have four sons and a daughter ranging in age from 28 to 13.

Other Program Information

The second scientific session will be held Friday morning, August 25. Two of the speakers and their topics for this session, as announced previously, will be "Surgical Management of Obesity"—Edward E. Mason, M. D., Professor of Surgery, University of Iowa Hospitals, and "The Medical Examiner System in West Virginia"—Irvin M. Sopher, M. D., of Charleston, Chief Medical Examiner, State of West Virginia.

Additional speakers and topics for the two scientific sessions will be announced in later issues of *The Journal.*

The Saturday morning General Session, as announced previously, will be devoted to a program presented by Karen Zupko, Director of the American Medical Association's Department of Practice Management. Ms. Zupko, a communications specialist, will discuss "Personnel: What You Need for Office Efficiency," and "Patient Relationships: Communications, Information, Rapport."

It also was announced previously that Dr. Tom E. Nesbitt of Nashville, Tennessee, has been invited to address the 2:30 P.M. Wednesday, August 23, opening House of Delegates session; and that James A. Reynolds, Editor of *Medical Economics,* will deliver the 9 A.M. Thursday keynote address. Doctor Nesbitt will be installed as President of the AMA in St. Louis in June.

Annual Meeting activities will get under way with a 2 P.M. meeting of the Association's Executive Committee on Tuesday, August 22; the usual pre-Convention meeting of the Council at 10 A.M. on Wednesday, and the opening House session Wednesday afternoon.

Serving with Doctor Gray on the Program Committee are Drs. Aarom Boonsue, Point Pleasant; Robert D. Hess, Clarksburg; James T. Hughes, Ripley; Barbara Jones of the West Virginia University School of Medicine faculty in Morgantown and Maurice A. Mufson of the Marshall University School of Medicine faculty in Huntington.

Early Reservations Advised

Meanwhile, reservation forms provided by the Greenbrier have been distributed to all Association members, and those planning to attend the Annual Meeting are encouraged to give them their earliest possible attention.

The Annual Meeting of the Auxiliary to the State Medical Association, with Mrs. Joseph T. Mallamo of Fairmont in charge as the Auxiliary's President, again will run concurrently with the Association's Convention.

Wildwater Surgical Conference In Charleston June 3

The "Fifth Wildwater Surgical Conference" will be held on Saturday, June 3, in Charleston by the Charleston Division/West Virginia University Medical Center and the Charleston Area Medical Center.

Larry C. Carey, M. D.

George J. Hill II, M. D.

The conference site will be the Auditorium of the WVU Medical Education Building at 3110 MacCorkle Avenue, S.E.

Registration will begin at 8 A.M., followed by a welcome from Dr. Thomas W. Mou, Dean of the Charleston Division/WVU; and an introduction by Dr. Alvin L. Watne, Professor and Chairman of Surgery, WVU Medical Center, Morgantown.

Larry C. Carey, M. D., of Columbus, Ohio, Professor and Chairman of Surgery, Ohio State University, will serve as moderator.

The speakers and their topics will be:

"Gastroschisis"—Thomas Boles, M. D., Professor and Chairman, Division of Pediatric Surgery, Children's Hospital, Columbus, Ohio; "Newer Concepts in Surgical Oncology"—George J. Hill II, M. D., Professor and Chairman of Surgery, Marshall University School of Medicine; "Surgical Therapy in Renal-Vascular Hypertension"—Bruce Stewart, M. D., Department of Surgery, Cleveland (Ohio) Clinic;

"Postgastrectomy Woes"—Caldwell B. Esselyn, Jr., M. D., Department of Surgery, Cleve-

land Clinic; "Cost Crisis in Medical Care"—William Kiser, M. D., Vice Chairman, Board of Governors, Cleveland Clinic; "Recurrent Acute Pancreatitis"—Doctor Carey, and "Precancerous Lesions of Colon and Rectum"—Michael Deddish, M. D., formerly Chairman, Colon-Rectal Surgery, Memorial Hospital for Cancer, and The Sloan-Kettering Institute for Cancer Research, Cambridge, Ohio.

The program meets the criteria for credit in Category 1 of the Physician's Recognition Award of the American Medical Association.

The conference is sponsoring a Wildwater Expedition for a limited number of persons on New River, from Prince to Thurmond, on Friday, June 2. The fee for the expedition is $42.

The conference fee, which includes lunch, is $20 for physicians and $5 for nurses.

Registrations and checks, which should be payable to WVU Foundation, Inc., may be sent to Conference Coordinator, Charleston Division/WVU Medical Center, 3110 MacCorkle Avenue, S.E., Charleston 25304. For additional information contact the Office of Continuing Education at the above address (phone 304/345-2600).

Medical, Nursing Appointments Announced By MU

Dr. Herbert H. Spencer, formerly Associate Dean and Professor of Medicine at the Medical College of Ohio, has accepted a dual post with the Marshall University School of Medicine and the Veterans Administration Hospital in Huntington.

He is serving as Associate Dean and Professor of Medicine of the medical school and as Chief of Staff at the VA Hospital.

Also announced recently was the dual appointment of Dr. Jon D. Cooksey of St. Louis, Missouri, a native of Ashland, Kentucky, and the appointment of Dr. Virginia O. Allen of Burlington, Vermont.

Prior to joining the faculty at the Toledo medical school, Doctor Spencer was Associate Professor of Internal Medicine at the University of Michigan Medical Center and Chief of Staff at the Ann Arbor VA Hospital.

A native of Michigan, he earned his A. B. and M. D. degrees from the University of Michigan, followed by postgraduate training at the University of Michigan Hospital. He later was a Research Associate in Hematology with the hospital's Simpson Memorial Institute.

Professor of Medicine

Doctor Cooksey is serving as Professor of Medicine and Chief of the Cardiology Section of the medical school's Medicine Department, in addition to his position as Chief of the Cardiology Section of the VA Hospital.

He has held several positions at Washington University's School of Medicine in St. Louis, including: Assistant Professor of Preventive Medicine, Assistant Professor of Medicine, Cardiologist for the Lipid Research Center, and Associate Director of the Irene Walter Johnson Institute of Rehabilitation.

He also was a cardiology consultant to the Jewish Hospital of St. Louis.

Doctor Cooksey attended the University of Kentucky and earned his M. D. degree from Tulane University. He served an internship at Henry Ford Hospital in Detroit. After a residency at Tulane University's Charity Hospital, he held a three-year cardiology fellowship at Washington University's School of Medicine.

Doctor Allen, currently an Associate Professor of Nursing and Head of the University of Vermont School of Nursing's two-year Associate Degree Program at Burlington, has been named Dean of the Marshall University School of Nursing. She will assume her duties in July with the rank of Professor.

Two Nursing Programs

As Dean of the School of Nursing. Doctor Allen will be in charge of the Associate and Baccalaureate Degree Nursing Education programs.

A member of the University of Vermont faculty since 1968, she established that school's Associate Degree in Nursing Program, and also is credited with establishing New England's first two-year Associate Degree Program at Newton Junior College, Newtonville, Massachusetts, in the early 1960s.

At the Vermont school, Doctor Allen also assists with the Baccalaureate and Nursing Practitioner programs.

She earned her Nursing Diploma from Monmouth Medical Center School of Nursing, Long Branch, New Jersey; her B. S. Degree in Nursing from Seton Hall University, Newark, New Jersey, and her Master of Arts Degree in Nursing Education and Administration from Columbia University. She recently received her Doctor of Education Degree with emphasis in Nursing Education, Curriculum and Instruction from Columbia.

The appointments were announced by Dr. Robert W. Coon, MU Medical School Dean.

Review A Book

The following books have been received by the Headquarters Office of the State Medical Association. Medical readers interested in reviewing any of these volumes should address their requests to Editor, *The West Virginia Medical Journal*, Post Office Box 1031, Charleston 25324. We shall be happy to send the books to you, and you may keep them for your personal libraries after submitting to *The Journal* a review for publication. *Meanwhile, please see reviews of the books, "Current Surgical Diagnosis and Treatment, 3rd Edition," "Current Medical Diagnosis & Treatment," "The Nervous System," "The New Way to Live with Diabetes," and "Pediatric Drug Handbook," beginning on page xx.*—Editor.

Coal Workers' Pneumoconiosis — A Critical Review, by Aleksandra J. Kujawska, M. D.; Kazimierz J. Marek, M. D.; and Witold W. Zahorski, M. D. 108 pages. University Press of New England, Hanover, New Hampshire.

American Drug Index 1977, by Norman F. Billups, Ph. D., R. Ph. 735 pages. Price $14.50. J. B. Lippincott Company, Philadelphia, Toronto.

Current Pediatric Diagnosis & Treatment, by C. Henry Kempe, M. D.; Henry K. Silver, M. D.; and Donough O'Brien, M. D. 1,102 pages. Price $17. 5th Edition. Lange Medical Publications, Los Altos, California 94022. 1978.

Dr. Charles A. Hoffman Author Of Book

Editor's Note: Dr. Charles A. Hoffman of Huntington, President of the State Medical Association in 1957-58 and President of the American Medical Association in 1972-73, has written a book entitled, *God, Man and Medicine*, which is reviewed below. Copies of the book are available through Charles A. Hoffman, M. D., P. O. Box 2507, Huntington 25725, at a cost of $10 plus 50 cents for handling. West Virginia residents should add 30 cents sales tax. For more information call Anne Weber, R. N., at (304) 525-2881.

God, Man and Medicine is a stirring personal account of Dr. C. A. (Carl) Hoffman's lifetime devotion to the practice of medicine.

Known locally to thousands of Tri-State Area residents, Doctor Hoffman has achieved national prominence in the medical profession during his 40-year career.

He has served in virtually every local and state medical association position and is a Past President of the American Urological Association and the American Medical Association.

In his new book, Doctor Hoffman reflects upon his boyhood in Ironton, Ohio, his practice in Huntington, West Virginia, and his travels and experiences as President of the powerful American Medical Association.

Written in Doctor Hoffman's "conversational" style, the book is very interesting and enjoyable reading.

It's extremely moving at times, as he recalls his close personal relationships with his patients and staff—and his deep love of life, his family and medicine.

And it's also very matter-of-fact as he outlines the inner workings of the American Medical Association.

He discusses in detail his trips to Russia and China—and his interesting exposure to treatment by acupuncture.

He gives his views on the problems of malpractice facing physicians today—and recalls with deep feeling his personal meetings with former President Johnson and former President Nixon.

Doctor Hoffman is a man with deep convictions and considerable influence. He has spoken in every state, numerous foreign countries, and is a recognized authority in his field.

God, Man and Medicine is the story of this extraordinary man—this extraordinary physician —who has devoted a lifetime to the betterment of his profession.—David Gannon.

Pediatric Lecture In Charleston

"The Pediatric Esophagus—Function and Dysfunction" will be the topic of a lecture by Dr. David H. Baker of New York City in Charleston on May 25.

Doctor Baker will speak at 8:30 P.M. in the Auditorium of the West Virginia University Charleston Division Medical Education Building, located at 3110 MacCorkle Avenue, S.E., adjacent to Memorial Division, Charleston Area Medical Center.

The lecture will be the fifth in CAMC's 1977-78 series of Pediatric Symposia open to all physicians and other personnel.

Doctor Baker is Professor and Director, Pediatric Radiology, Columbia-Presbyterian Medical Center, New York City.

Continuing Education Activities

Here are the continuing medical education activities listed primarily by the West Virginia University School of Medicine for part of 1978, as compiled by Dr. Robert L. Smith, Assistant Dean for Continuing Education. The schedule is presented as a convenience for physicians in planning their continuing education program. (Other national, state and district medical meetings are listed in the *Medical Meetings* Department of *The Journal.*)

The program is tentative and subject to change. It should be noted that weekly conferences also are held on the Charleston and Wheeling campuses as well as in Morgantown. Further information about these may be obtained from: Division of Continuing Education, WVU Medical Center, 3110 MacCorkle Avenue, S.E., Charleston 25304; Office of Continuing Medical Education, WVU Medical Center, Morgantown 26506; or, Office of Continuing Medical Education, Wheeling Division, WVU School of Medicine, Ohio Valley Medical Center, 2000 Eoff Street, Wheeling 26003.

May 11, 12	Morgantown	Epidemiology for Health Officers
May 19, 20	Charleston	Renal Symposium
June 3	Charleston	Fifth Annual Wildwater Surgical Conference
June 17	Morgantown	Common Arrhythmias and Their Management

Nurses, Physicians To Discuss Joint Practice Concepts

Nurses, physicians and administrators will discuss innovative practical applications of joint practice concepts in the three-day Third National Conference on Joint Practice in Dallas on November 9, 10 and 11.

The National Joint Practice Commission (NJPC), with the American Medical Association and the American Nurses' Association as cosponsors, has planned 10 conference workshops on crucial joint practice issues. Participants and conference staff are expected to contribute significantly to their solution.

Conferees will hear the first report to the health professions on the NJPC's demonstration project to introduce joint or collaborative practice in four participating hospitals. This project, funded by the W. K. Kellogg Foundation, will run to the middle of 1980.

Nationally-known medical and nurse educators will participate in a forum on how to educate nurses and physicians for collaborative practice through interdisciplinary education.

Dr. Richard E. Flood of Weirton, Chairman of the State Medical Association's Nurses Liaison Committee, is a Commissioner of the NJPC. The NJPC is an interprofessional organization to improve health care established by action of the AMA and the ANA.

Renal Symposium By WVU, CAMC May 19-20

The second biennial Renal Symposium will be held in Charleston May 19-20 by the Charleston Division/West Virginia University Medical Center and the Charleston Area Medical Center.

The meeting site will be the Auditorium of the WVU Education Building, 3110 MacCorkle Avenue, S.E.

The symposium will begin with registration at 12:15 P.M. Friday, May 19, followed by a welcome at 1 P.M. from Dr. Thomas W. Mou, Dean of the Charleston Division/WVU.

Dr. Mary Lou Lewis, Charleston urologist and Clinical Professor of Medicine, Charleston Division/WVU, will be the moderator for the Friday afternoon session on "Fluid and Electrolytes."

The speaker Friday afternoon will be Dr. Robert J. Anderson, Assistant Professor of Medicine, Division of Renal Diseases, University of Colorado. Doctor Anderson will make three presentations: "Practical Electrolyte Problems I: Sodium & Magnesium," "Practical Electrolyte Problems II: Potassium & Phosphorus," and "Practical Electrolyte Problems III: Calcium & Chloride."

Completing the Friday afternoon agenda will be workshop sessions on "Management of Fluid and Electrolytes" to be conducted by Doctor Lewis, Doctor Anderson, Dr. Alfred K. Pfister of Charleston, Clinical Professor of Medicine, Charleston Division/WVU; Dr. Tahir Shafi of Charleston, Clinical Professor of Medicine, Charleston Division/WVU, and Dr. Jovan Milutinovich, Chairman, Division of Nephrology, WVU School of Medicine, Morgantown.

Open Session Friday Evening

Dr. George E. Schreiner, Professor of Medicine and Director of Nephrology, Georgetown University School of Medicine, Washington, D. C., will speak at 8 P.M. Friday in the Auditorium. His topic will be "Government Impact on the Quality of Medical Care."

Doctor Schreiner is President Elect of the International Society of Nephrology.

This session is open to persons who do not register for the symposium; preregistration is not necessary.

The Saturday morning session on "Drugs and the Kidney" will be moderated by Doctor Milutinovich. The speakers and topics will be:

"Drug-Induced Renal Disease"—Doctor Anderson; "Management of Acute Intoxication by Extracorporeal Techniques"—Doctor Schreiner, and "Pitfalls in the Use of Drugs in Renal Failure"—Doctor Anderson.

The recess for lunch will consist of "working luncheons" on the "Practical Management of Drugs" conducted by Dr. Marshall W. Ashby, Assistant Professor of Surgery, WVU, Morgantown; Dr. William E. Braun, Division of Research & Renal Hypertension, and Chief of Renal Transplantation Service, Cleveland (Ohio) Clinic; and Doctors Schreiner, Anderson, Lewis, Milutinovich and Shafi.

"End-Stage Renal Disease" will be the subject for the Saturday afternoon session, with Doctor Ashby moderating. The speakers and their topics will include "Chronic Renal Failure—Update on Conservative Management"—Doctor Schreiner; "Transplant Update"—Doctor Braun, and "Dialysis Update"—Doctor Schreiner.

Program Accredited

The symposium will adjourn at 4:15 P.M. following questions and discussion, with Doctors Schreiner and Braun in charge.

This program meets the criteria for nine and one-half hours of credit in Category 1 of the Physician's Recognition Award of the American Medical Association—and also is acceptable for 12 Prescribed hours by the American Academy of Family Physicians, and 1.1 Continuing Education Units (CEU's).

The registration fee, which includes the Saturday luncheon, will be $30 for physicians ($35 after May 15), $10 for allied health personnel ($15 after May 15), and $4 (cost of lunch only) for residents and students. The Friday evening banquet fee (optional) will be $10 per person.

For additional information contact the Office of Continuing / Consumer Education (phone 304/345-2600, extension 244 or 242.

38 Of 82 WVU Grads To Take Postgraduate Work In State

Beginning their first postgraduate year July 1 in a variety of locations will be members of the class of 1978 at West Virginia University School of Medicine.

Thirty-eight of the 69 men and 13 women will remain in West Virginia for their residencies and more than half the class (44) will enter primary care specialties.

Internal medicine proved the most popular choice (24), with family practice (12) next. Some of the 10 who chose a flexible first postgraduate year will probably select a primary care specialty later.

Other types of programs chosen and the number in each include anesthesiology (5), obstetrics/gynecology (4), orthopedic surgery (3), pathology (4), pediatrics (4), psychiatry (4), radiology (7), and surgery (8).

Class members, their home towns and destinations are:

Jay D. Angeluzzi, Parkersburg, University of Arizona Medical Center, Tucson; John J. Astrino, Fairmont, and Richard W. Ball, Triadelphia, Children's Hospital of Akron, Ohio; Terry L. Barrett, Princeton, National Naval Medical Center, Bethesda, Md.; James H. L. Beeghly, Bruceton Mills, Mary Imogene Bassett Hospital, Cooperstown, N. Y.; David A. Bowman, Bluefield, Allegheny General Hospital, Pittsburgh, Pa.; Edwyn L. Boyd, Wheeling, Roanoke (Va.) Memorial Hospital; Robert E. Boyd, Talcott, University of Virginia Hospital, Charlottesville; Charles P. Capito, Weirton, Charleston Area Medical Center (CAMC); James M. Carrier, Keyser, WVU Department of Surgery.

Stephen P. Cassis, Charleston, CAMC; Malcolm L. Chaney, Charleston, Kanawha Valley Family Practice Program; Candace C. Chidester, Morgantown, Eastern Virginia Graduate Medical School, Norfolk; Patsy P. Cipoletti, Wellsburg, Ohio State University Hospital, Columbus; Ronald L. Cleavenger, Clarksburg, WVU Department of Family Practice; Robin K. Conner, Anmoore, WVU Department of Anesthesiology; Thomas O. Dickey, Glen Dale, WVU Department of Behavioral Medicine and Psychiatry; Ade R. Dillon, Appleton, Wisc., University Hospitals, Madi-

son, Wise.; Gregory L. Eads, Kincaid, Orange Memorial Hospital, Orlando, Fla.; Patricia R. Evans, Glen Dale, North Carolina Baptist Hospital, Winston-Salem.

Robert W. Farr, Morgantown, City of Memphis (Tenn.) Hospital; Joseph C. Franz, Bridgeport, Elgin Air Force Base, Florida; Edward J. Gallagher, Shepherdstown, Kanawha Valley Family Practice Program; Billy F. Gardner, Belle, Hamot Medical Center, Erie, Pa.; Charles W. Gardner, Virginia Beach, Va., First Colonial Family Practice Center, Virginia Beach; Robert E. Gaylor, Wheeling, Miami Valley Hospital, Dayton, Ohio; Craig A. Gilpin, Charleston, Indiana University Medical Center, Indianapolis; Larry J. Godfrey, Glenville, Tripler Army Medical Center, Honolulu; Lawrence S. Gross, Huntington, WVU Department of Behavioral Medicine and Psychiatry; David A. Guthrie, Huntington, WVU Department of Surgery; Ernest S. Guy, Philippi, WVU Department of Medicine.

Jeffrey S. Hallett, Wheeling, Wilford Hall USAF Medical Center, San Antonio, Tex.; John M. Haught, Huntington, CAMC; John A. Holster, South Charleston, WVU Department of Pediatrics; Thomas W. Howard, Mt. Hope, CAMC; Janis L. Hurst, Bridgeport, WVU Department of Radiology; James C. Jarrell, Ravenswood, Andrews Air Force Base, Maryland; Jo Allen Jones, Williamstown, WVU Department of Family Practice; James R. Judge, Weirton, Rockford (Ill.) Medical Education Foundation; Lucille K. Kirchner, Morgantown, Hamot Medical Center, Erie, Pa.; Gary A. Kocher, Reader, Richland Memorial Hospital, Columbia, S. C.; Rodney F. Kovach, Morgantown, WVU Department of Radiology.

Mark C. Leeson, Weirton, Akron (Ohio) General Hospital; James C. Lesnett, Kingwood, Kanawha Valley Family Practice Program; George E. Lovegrove, Franklin, CAMC; Peter J. Lukowski, South Charleston, Portsmouth (Va.) Naval Hospital; Morgan H. Lyons, Philippi, and Michael A. Malamisura, Bluefield, WVU Department of Medicine; Pamela J. Mardones, Clarksburg, WVU Department of Surgery; Stuart A. Markowitz, Belmont, Calif., Pacific Medical Center-Presbyterian, San Francisco; Marilyn A. Martin, Glasgow, WVU Department of Behavioral Medicine and Psychiatry; David C. McCarus, Charleston, CAMC; David H. McDaniel, Bridgeport, WVU Department of Pathology; Richard E. McWhorter, Fairmont, George Washington University, Washington, D. C.

Donald H. Michels, West Union, Ohio Valley General Hospital, Wheeling; Joseph M. Neal, Huntington, Virginia Mason Hospital, Seattle, Wash.; Bruce N. Nelson, Bluefield, WVU Department of Medicine; William N. Payne, Huntington, CAMC; Charles D. Petit, Huntington, Washington University Affiliated Hospitals, St. Louis, Mo.; Dianne L. Petrone, Pittsburgh, Pa., Hartford (Conn.) Hospital; Dale R. Pokorney, Wheeling, William A. Shands Teaching Hospital, Gainesville, Fla.; Jeff L. Poling, Philippi, St. Thomas Hospital, Akron, Ohio; Donald L. Powell, Triadelphia, CAMC; Norman L. Rexrode, Summersville, Bristol (Tenn.) Memorial Hospital.

Roger S. Riley, Deer Park, Md., WVU Department of Pathology; John M. Rollins, Bridgeport, Travis Air Force Base, California; Frank L. Schwartz, Parkersburg, WVU Department of Medicine; Ellen S. Shaw, Monongah, Medical College of Virginia, Richmond; Richard A. Silman, Charleston, WVU Department of Anesthesiology; Charles J. Singer, Wheeling, Presbyterian Medical Center, Denver, Colo.; Richard G. Spurlock, Huntington, University of Kentucky Medical Center, Lexington; Jerry E. Squires, Morgantown, University of Virginia Hospital, Charlottesville.

David W. Thomas, Sutton, CAMC; William C. Thompson, Beckley, Jacksonville (Fla.) Educational Program; Sheila J. Walkup, Leslie, CAMC; Thomas L. Warren, Morgantown, WVU Department of Anesthesiology; Deborah A. Willard, Charleston, WVU Department of Radiology; Susan K. Woelfel, Huntington, WVU Department of Anesthesiology; Gordon K. Wolfe, Petersburg, St. Luke's Hospital, Denver, Colo.; Edward E. Wright, Pine Grove, Kanawha Valley Family Practice Program; John C. Y. Wright, Sistersville, Miami Valley Hospital, Dayton, Ohio, and Patricia J. Zekan, Charleston, North Carolina Baptist Hospital, Winston-Salem.

Doctor Marcelo On Committee Of Medical Women's Group

Dr. Josefina Q. Marcelo of Berkeley Springs has been appointed to the Resolutions Committee of the American Medical Women's Association (AMWA).

The Resolutions Committee is responsible for the collection of resolutions from officers, branches, committees, delegates and active members of the association to be considered at the convening session of the House of Delegates.

Doctor Marcelo is a native of the Philippines and received her M. D. degree from the Univer-

sity of Santo Thomas there. She continued her medical education when she came to the United States, with internships at Tucson Medical Center and Pima County Hospital, Tucson, Arizona. A General Practice residency was completed at the Robinson Memorial Portage County Hospital in Ravenna, Ohio.

She presently is on the medical staff of War Memorial Hospital in Berkeley Springs.

CME Program Of Weirton Medical Center Accredited

The continuing medical education program of the Weirton Medical Center has been accredited by the State Medical Association through its Committee on Medical Education and Hospitals.

The hospital was granted a two-year provisional accreditation for a newly-developing program, effective March 17, 1978. Credit for Category 1 of the Physician's Recognition Award of the American Medical Association is effective retroactively to the date of the site survey, February 9, 1978.

Serving on the survey team were Drs. John W. Traubert of Morgantown, Chairman, and George E. Kellas of Wheeling.

Including Weirton Medical Center, the CME programs of 13 state hospitals and four medical organizations have been accredited by the State Medical Association.

Sports Medicine Conference

Physicians will learn the latest methods of treating athletic injuries at the American Medical Association's 20th Conference on Medical Aspects of Sports.

The Conference will be held Saturday, June 17, in St. Louis (Stouffer's Riverfront Towers) in conjunction with the 127th Annual Convention of the AMA.

MEDICAL WRITING

Experienced medical writer with pharmacy degree will ghostwrite, rewrite, edit or proofread technical or general papers, articles, textbooks, handouts, educational materials etc. Local references available, fees mutually agreed before work commences. J. Marion Anderson, 90 School St., Morgantown WV 26505. Telephone 304-599-9319.

Medical Meetings

May 3-6—Am. Pediatric Surgical Assn., Hot Springs, Va.

May 3-6—W. Va. Chapter, ACS, White Sulphur Springs.

May 4-7—ASIM, San Francisco.

May 6—Air Pollution & Health Effects, Charleston.

May 6-10—Ohio State Medical Assn., Dayton.

May 8-12—Am. Psychiatric Assn., Atlanta.

May 10-12—Med. & Chirurgical Faculty of the State of Md., Hunt Valley, Md.

May 14-17—Am. Thoracic Society, Boston.

May 17-18—Advanced Cardiac Life Support Instructor Course, Morgantown.

May 21-25—Am. Urological Assn., Washington, D. C.

May 25—Pediatric Lecture, Charleston Area Medical Center, Charleston.

May 26-27—AMA Medical Staff Leadership Seminar, New York City.

June 10—W. Va. State Society of Anesthesiologists, Morgantown.

June 11-13—Am. Diabetes Assn., Boston.

June 11-15—Am. Society of Colon & Rectal Surgeons, San Diego.

June 17-22—AMA Annual Meeting, St. Louis.

Aug. 23-26—111th Annual Meeting, W. Va. State Medical Assn., White Sulphur Springs.

Sept. 10-14—Am. Academy of Ophthalmology & Otolaryngology (Otolaryngology Section), Las Vegas.

Sept. 17-21—Kentucky Med. Assn., Louisville.

Sept. 25-28—AAFP, San Francisco.

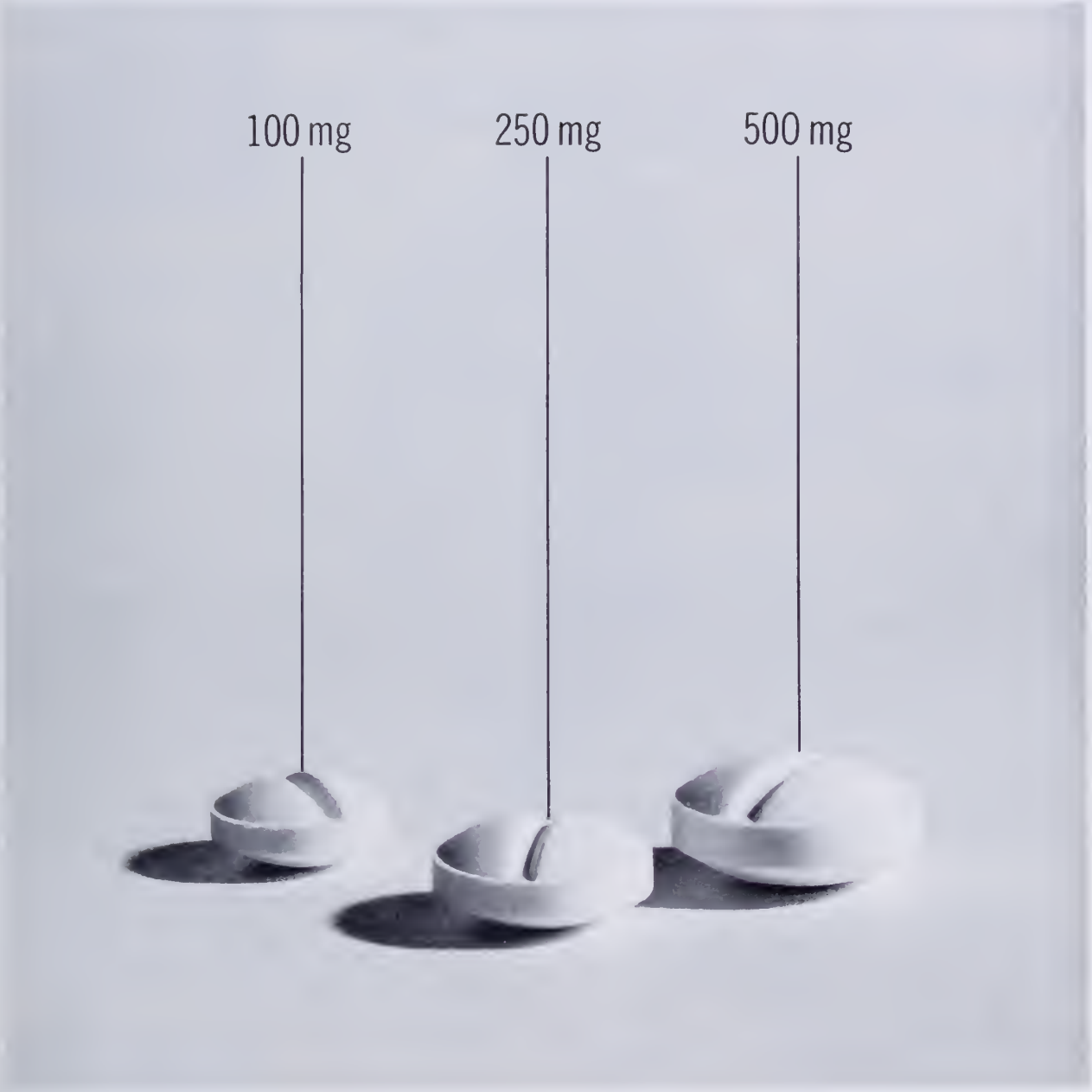
Oct. 25-29—Am. Academy of Child Psychiatry, San Diego.

Nov. 2-5—Med. Society of Virginia, Williamsburg.

Nov. 11-14—Southern Medical Assn., Atlanta.

1979

Jan. 26-28—12th Mid-Winter Clinical Conference, Charleston.



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WVU Medical Center
—News—

Compiled from material furnished by Mrs. Mary Ellin Wylie, Director, Medical Center News and Information Services, Morgantown, W. Va.

Fast-Growing Pain Clinic Amounts To 'Court Of Last Resort'

An outpatient clinic for treatment of pain that just won't go away is one of the fastest-growing services at the West Virginia University Medical Center.

The pain clinic, one of only a dozen of its kind in the nation, opened in 1975 with four patients. During the fiscal year that ended last June, it treated 377 persons, and at present rates will provide services to 550 or more this year.

Clinic Director Robert Bettinger, M. D., says the clinic amounts to a "court of last resort" for persons suffering chronic and disabling pain that usually has persisted six to 12 months or longer.

Doctor Bettinger is Assistant Professor of Anesthesiology in the WVU School of Medicine, and the clinic is the responsibility of that department.

Anesthesiologists got into pain clinic work as "sort of a back door thing," according to Dr. William R. Henrick, Assistant Professor, and Dr. Richard Knapp, Professor and Chairman of Anesthesiology.

"There are a few painful clinic states which are readily diagnosed and can be treated by nerve block therapy," Doctor Henrick explained. "Physicians would recognize what was wrong and know what needed to be done, but they weren't equipped by training or experience to administer a nerve block. So they turned to the anesthesiologist."

Nerve blocks have been especially effective in treating patients with low-back pain not caused by herniated discs—and patients with back problems account for more than half of the clinic's patients.

Other types of pain treated include those caused by cancer, shingles, surgical incisions and accidental injuries including fractures. The clinic doesn't treat patients suffering from recurring headaches (at the WVU Medical Center, they are seen by the neurology service).

All of the pain clinic patients have seen at least one other physician who has been unable either to determine the cause of the pain or to prescribe a successful therapy. All have been screened for correctable physical problems.

"What we try to do is to go back to the very beginning of the problem and to sort out from a little broader view what has been happening," Doctor Bettinger said.

"We take a multi-disciplinary approach in evaluating patients for various modes of therapy because many of these patients require more than one type of treatment."

One of the treatments might be the use of a nerve stimulator which discharges an electrical current through the skin to the pain site. A little larger than a hearing aid, the stimulator can be operated by the patients themselves.

Acupuncture Used

Acupuncture has been used successfully in selected patients. This is performed by Dr. William Hess, Assistant Professor of Anesthesiology.

Antidepressant medication and tranquilizers as well as psychological therapy also are helpful in some cases.

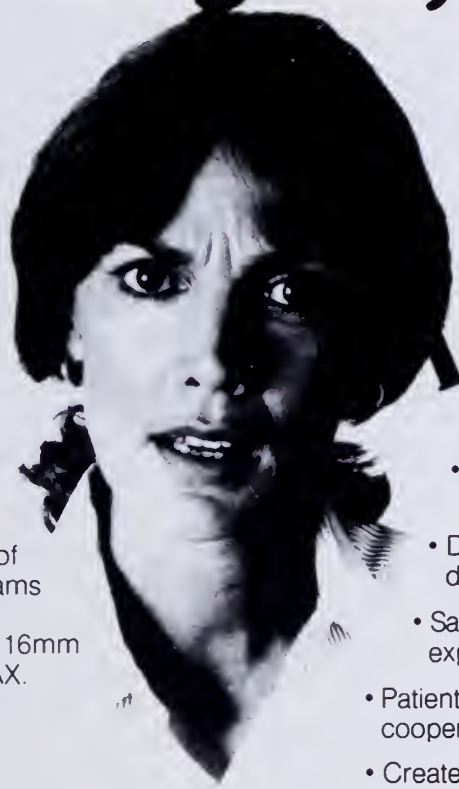
If all else fails, either surgical or chemical destruction of the spinal nerves carrying the pain impulses may be done. This is used most frequently for terminal cancer patients with intractable pain.

Patients are taken at the WVU clinic by referral only, with appointments made by referring physicians from throughout West Virginia.

"Therapy to kill the pain is only half the story," Doctor Bettinger said. "The other part is rehabilitation."

Physicians in the pain clinic counsel the patients on activity, employment and living habits. Exercises may be prescribed or the patient may be referred to the Division of Physical Therapy.

"I still don't understand. Can you explain it again, Doctor?"



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Third-Party News, Views and Program Concerns

Nationwide Now Processing UMW Medicare Claims

The United Mine Workers Health and Retirement Funds, effective March 1, no longer process claims submitted on behalf of UMW/Medicare patients for services rendered on and after December 6, 1977.

This was announced recently by Nationwide Mutual Insurance Company, the Part B Medicare carrier serving West Virginia and Ohio. All claims for services on and after December 6, 1977, should be submitted directly to Nationwide-Medicare, the company stated.

Claims for services *prior* to the above date were to be accepted and processed by the UMW Funds through March 24, Nationwide continued, adding that—after that date—all such claims should be submitted to Nationwide-Medicare.

Nationwide advised that UMW/Medicare claims must be billed in a manner consistent with other Medicare claims. All billing requirements pertaining to itemization, patient signature, diagnosis, etc., must be complied with before processing can be completed, the company observed.

New Mexico Health Official Named Medicaid Head

Richard W. Heim, former Executive Director of New Mexico's Health and Social Services Department, has been named head of the Medicaid Bureau of the United States Department of Health, Education and Welfare. The announcement was made recently by HEW Secretary Joseph A. Califano, Jr.

The Medicaid Bureau is a major component of the Health Care Financing Administration. HCFA was established by Secretary Califano in March, 1977, to bring Medicaid and Medicare, the Department's principal health care financing organizations, together in one organization.

"Dick Heim is a talented and imaginative executive, and I am most pleased that he has agreed to take this very important post," HCFA Administrator Robert A. Derzon said. "His experience and expertise with the Medicaid program will help greatly in our efforts to see the Medicare and Medicaid programs serve their high purposes well."

"He brings to the Medicaid Bureau the valuable asset of having worked closely with several state governments, and he has earned the high regard of state Medicaid directors," Derzon said. "His accomplishments during an outstanding career demonstrate both his commitment to helping the poor of our country and his management skills in initiating creative ways to meet that commitment," he added.

FDA Approves Valproate For Epilepsy

The Food and Drug Administration of the U. S. Department of Health, Education, and Welfare recently approved valproate (valproic acid), a prescription drug for the treatment of patients with a certain type of epilepsy.

The drug was approved for treatment of patients who suffer temporary seizures in which they lose consciousness for a few seconds, a condition known as petit mal epilepsy.

Valproate is likely to be useful in the treatment of a significant number of epileptic patients who do not respond well to currently-available drugs.

The drug will be sold in capsule and liquid form by Abbott Laboratories under the brand name Depakene.

A document about valproic acid, "Summary for Basis of Approval," is available to interested physicians by writing (enclosing a self-addressed label): Office of Professional Programs, Public Health Service, Food and Drug Administration, Department of Health, Education and Welfare, Rockville, Maryland 20857.

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Obituaries

ARTHUR S. JONES, M. D.

Dr. Arthur S. Jones of Proctorville, Ohio, founder of Huntington Hospital, died on March 10 at the hospital. He was 92.

Doctor Jones was the first orthopedic surgeon to practice in West Virginia. He organized the old Huntington Children's Hospital in 1923. The name of the hospital was first revised to the Huntington Orthopedic Hospital and later to Huntington Hospital.

Doctor Jones also is credited with helping start the Morris Memorial Hospital at Milton.

He had been living at his Proctorville farm since retiring in 1968.

Doctor Jones years ago traveled throughout West Virginia to provide medical and surgical assistance to crippled children. He received financial aid from various civic organizations; however, he paid his own traveling expenses.

His efforts to help crippled children resulted in a $40,000 appropriation—the first ever—from the state Legislature for the treatment and care of crippled children. The program became so successful that it, along with other state agencies. formed the Department of Public Welfare which later became the Department of Public Assistance.

A native of Obids, North Carolina, Doctor Jones received his M. D. degree in 1910 from the University of Virginia Medical School. He interned at Lakeside Hospital in Cleveland, and did postgraduate work in New York City, Boston and abroad.

A veteran of World War I, Doctor Jones was an honorary member of the Cabell County Medical Society, the West Virginia State Medical Association and the American Medical Association.

Survivors include the widow; a son, David Jones, at home, and a daughter, Mary Hannah Jones, a student at St. John's College in Maryland.

* * *

PAUL R. WILSON, M. D.

Dr. Paul R. Wilson of Piedmont, a retired urologist, died on March 13 in a Keyser hospital. He was 80.

Doctor Wilson practiced in Keyser for 50 years before retiring in 1976.

(Continued on Page xix)

BRIEF SUMMARY OF
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ANTIMINTH® (pyrantel pamoate)
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Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13 μg/ml) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

The drug has not been extensively studied in children under two years; therefore, in the treatment of children under the age of two years, the relative benefit/risk should be considered.

Precautions: Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with preexisting liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg of pyrantel base/ml) should be administered in a single dose of 11 mg of pyrantel base per kg of body weight (or 5 mg/lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 ml of Antiminth per 10 lb. of body weight. (One teaspoonful=5 ml.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

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(Continued from Page xviii)

A former member of the Mineral County Board of Education, he was a veteran of both World War I and World War II.

He served as President and Secretary of the Potomac Valley Medical Society in the 1930s.

Doctor Wilson, a native of Wilson (Grant County), was graduated from West Virginia University and received his M. D. degree from the University of Maryland School of Medicine in 1925.

He interned at Fairmont State Hospital and did postgraduate work at Polyclinic Hospital in New York City.

Doctor Wilson was an honorary member of the Potomac Valley Medical Society, the West Virginia State Medical Association and the American Medical Association.

Surviving are two daughters, Mrs. Joanne Jones of Hagerstown, Maryland, and Mrs. Rosemary Kinney of Silver Spring, Maryland; and four sisters, Mrs. Virginia Turner of Tampa, Florida, Mrs. Marion Getty of Westernport, Maryland, and Mrs. Alice Sellar and Mrs. Lillian Merrell, both of Leesburg, Florida.

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County Societies

MONONGALIA

The Monongalia County Medical Society met on March 7 at the Old Mill Club in Morgantown.

The scientific program was presented by Dr. George E. Pickett of Charleston, Director of the West Virginia Department of Health. His topic was "The Changing Health Department."

The Society approved a proposal by Dr. Ronica Kluge for an investigation of Russian flu vaccine involving local school children.—Barbara Jones, M. D., Secretary.

* * *

FAYETTE

The Fayette County Medical Society met on March 1 at Montgomery General Hospital.

Mr. Charles R. Lewis of Charleston, Executive Secretary of the West Virginia State Medical Association, gave an interesting and informative account of the bills in the State Legislature pertaining to medical affairs.

The Society approved a donation of $25 to Camp Kno-Koma.—Joe N. Jarrett, M. D., Secretary.

* * *

McDOWELL

The McDowell County Medical Society met on March 8 at Stevens Clinic Hospital in Welch.

The scientific program consisted of a movie regarding the technique of joint examination. Differential diagnosis of rheumatoid arthritis, osteoarthritis, and ankylosing spondylitis was discussed in the film.—Muthusami Kuppusami, M. D., Secretary.

ASPEN MUSHROOM CONFERENCE

Identification of edible, poisonous, and hallucinogenic mushrooms. Treatment of mushroom poisoning. Microscopy. Novice and advanced courses. AMA Category I. August 13-18, 1978. Wildwood Inn, Snowmass-at-Aspen, Colorado. Contact Beth Israel Hospital, 1601 Lowell Boulevard, Denver, Colorado 80204. Telephone (303) 825-2190, Extension 359.

Book Review

CURRENT SURGICAL DIAGNOSIS AND TREATMENT, 3rd EDITION—J. Engelbert Dunphy, M. D.; Lawrence W. Way, M. D., and associate authors. Lange Medical Publications, Los Altos, California 94022. 1139 Pages. 1977. Price $18.

The material in this surgical text is very well presented and the topics are divided into various organ systems and specialties, like Orthopedics, Gynecology, Neurosurgery, and Otolaryngology.

The general presentation is similar to the previous edition, except that certain chapters, like the one on surgical nutrition, have been improved and updated. There is a new chapter on special diagnostic procedures which discusses the newer diagnostic modalities like ultra-sonography and CT scanning in a very clear and concise fashion.

The crisp nature in which the subjects are dealt with makes the book invaluable, not only for the busy practitioner, but also for the surgical residents in training and preparing for their surgical boards.

The lists of references given at the end of each chapter are adequate and pretty well up-to-date.

The chapters on surgical physiology, like fluid and electrolyte imbalance, are nicely dealt with in a very practical fashion. Medical students, however, would find this book insufficient as a sole surgical text since more in-depth reading is needed in areas which are basic to surgery such as surgical physiology and anatomy.

All in all, the book should be a valuable addition to every physician's reference library for a very moderate price of $18.—P. M. Rao, M. D.

CURRENT MEDICAL DIAGNOSIS & TREATMENT—Marcus A. Krupp, M. D.; Milton J. Chatton, M. D.; and associate authors. Lange Medical Publications, Los Altos, California 94022. 1,098 Pages. 1978. Price $17.

Doctors Krupp and Chatton from Stanford and 31 associate authors have made the 16th yearly revision of *Current Medical Diagnosis and Treatment* a fine reference manual. As the authors state, "(It) is intended to serve the practicing physician as a useful desk reference on widely accepted techniques currently available for medical diagnosis and treatment." It is geared both for the generalist and for the specialist who requires periodic update on occasionally-seen problems.

There are 33 chapters, beginning with general symptoms and proceeding through a discussion of metabolic disorders, disease of various bodily systems, on to a very good review of psychiatric disorders, infectious diseases, poisons, genetics, malignancies and immunologic disorders. The approach is practical, concise and up-to-date. A handy appendix is attached, discussing the problem-oriented record, recommendations for immunization, foreign travel, emergency medical evaluation and normal laboratory values. The table of contents and the index are easily used.

This book has good utility for nearly any practicing physician—Ralph S. Smith, Jr., M. D.

THE NERVOUS SYSTEM—W. F. Ganong, M. D. Lange Medical Publications, Los Altos, California 94022. 226 Pages. 1977. Price $8.

This is a review of the physiology and functions of the nervous system. It is geared for students of human physiology, particularly medical students, although practitioners in the fields of neurological medicine (psychiatry, neurology, and neurosurgery) could utilize the book as an up-to-date review. After reviewing physiological properties of excitable tissue, including nerve, skeletal, cardiac and smooth muscle and the synaptic transmission, the author then reviews the special sense organs correlating anatomy and physiology. Other special areas such as control of posture and movement, neurophysiologic basis of instinct, behavior and emotions and higher functions of the nervous system attempt a similar coordination of anatomy and physiology, although they are superficial in approach and not as well documented.

This book has limited applicability to the practicing physician.—Ralph S. Smith, Jr., M. D.

THE NEW WAY TO LIVE WITH DIABETES—Brian Boylan and Charles Weller, M. D. Doubleday & Company, Inc., 245 Park Avenue, New York, New York 10017. 140 Pages (paperback). 1966 (revised 1976). Price $2.50.

Discouraged by the social stigma and humdrum attitude attached to their condition, diabetic readers will welcome this light and fast-moving guide. The authors adequately define diabetes and outline the standard etiologies and treatments. The book fails, however, to develop

the base of medical expertise concerning diabetes since the original 1966 edition. Hints at reclassification of diabetes in the first chapter appear to be the only change in the new book. There is no mention of laser photocoagulation treatment for diabetic retinopathy. Still, the book offers good advice and a positive outlook for the diabetic.

A major premise advocated by the authors involves the diabetic's functional place in our society. They stress the need to educate teachers to treat diabetic students as normal, to orient the business world to the diabetic's ambitions and to encourage parents to release their overdependent strongholds on their diabetic children. In turn, they emphasize, the diabetic can live a normal and constructive life if he is willing to take care of himself.

The book is broad in scope and presents straightforward and sound advice to the ever-frustrated diabetic and his family. It is a sensible and enlightening guide and may be less pessimistic than more wordy treatments of this subject.—Juanedd Berry, M. D.

PEDIATRIC DRUG HANDBOOK—Harry C. Shirkey, M. D., D. Sc. (Pharm.) Hon. W. B. Saunders Company, West Washington Square, Philadelphia, Pennsylvania 19105. 198 Pages. 1977. Price $5.95.

The usefulness of Doctor Shirkey's Table of Drugs has long been known. The older generation of pediatricians first made enthusiastic use of it as a section of Nelson's Textbook of Pediatrics in 1959. It continued to find new and equally enthusiastic users through subsequent editions. Now, Doctor Shirkey has put the Table of Drugs into a most useful format with the publication of the Pediatric Drug Handbook. The volume fits neatly into the average laboratory coat pocket.

The author has had a long experience in teaching pediatric drug therapy to undergraduate medical students as well as students in postdoctoral programs. The quality of his previous publications on this subject has been excellent. Doctor Shirkey has applied his experience to the development of this book. He again expresses his concern regarding the fact that "many drugs released since 1962 have not been sufficiently tested in children to permit precise recommendations regarding dosage. Such drugs, causing children to be 'therapeutic orphans,' may be listed with restrictions on use in children (unapproved use) or adult dosage only may be listed." The orphaning clauses are carried in this table.

Doctor Shirkey comments briefly on Pediatric Pharmacokinetics. A Nomogram for estimation of surface area (West), and one for relationships between body weight in pounds, body surface area and adult dosage (Talbot) are supplied. In the Table itself, drugs are grouped by generic name according to therapeutic use. Trade names, available forms, dosage, contraindications, warnings, precautions and adverse reaction information then follows. National official compendia listing is noted when indicated.

The handbook has a complete and useful Table of Contents. The drugs are indexed by both generic and trade names, a system most useful to the practitioner.

The volume has a dozen blank pages in the back so that the owner may add additional drug notes of his own, thus keeping his volume up to date in the interim between what the reviewer hopes will be relatively frequent new editions. The format and paperback binding would seem to indicate that to be the author's intention.

The handbook is complete, practical and recommended to all who care for children.—Thomas G. Potterfield, M. D.

EMERGENCY PHYSICIANS

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We are a group of primarily full-time career oriented emergency physicians who are staffing the Fairmont Emergency Department as of May 1, 1978.

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Supporting the individual emergency physician at the various hospitals is our group's administrative staff. The knowledge, expertise, and experience of this administrative group is shared willingly, openly and candidly with the hospital, the emergency physicians, and the patient, in an attempt to provide the highest quality emergency medical services possible.

In conclusion, we believe we've organized, structured, and successfully developed one of the finest emergency physician group practices in the country.

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AMA Has New Committee on Services to Young Physicians

The AMA now has an Ad Hoc Committee on Services to Young Physicians. Objectives of the 11-member group are to determine the needs of young practicing physicians in order to recommend the modification of existing AMA activities and creation of new services.

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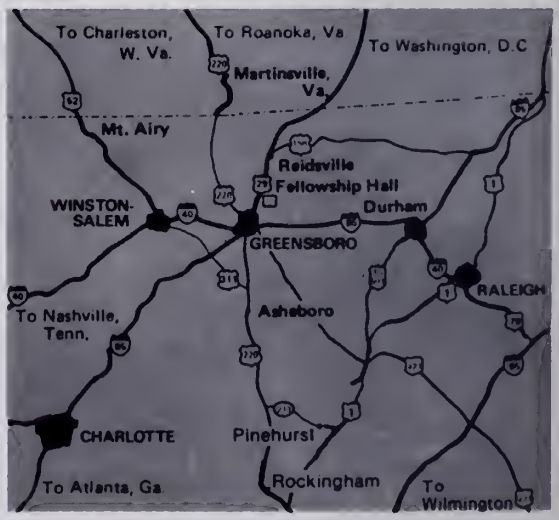

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Spontaneous Peripelvic Extravasation Of Urine

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A rare but interesting case of spontaneous peripelvic extravasation of urine is presented. Its pathophysiology and management are briefly discussed.

EXTRAVASATION of the contrast material from the collecting system of the kidney is a well-recognized occurrence on retrograde pyelography,[1,2,3] but extravasation on intravenous urography has been described in only a few reports. The first such report came from Fuchs in 1930.[4] Since then, sporadic reports have appeared in the literature.[5-24]

There is some controversy regarding the terminology. Literally speaking, "spontaneous" means "self-originated or acting by its own impulse." If follows that for extravasation to be truly spontaneous there should be no history of trauma, no ureteral instrumentation, no recent operation on the kidney, upper ureter or immediate vicinity, and no external compression during urography. In addition, Schwartz *et al* propose that there should be no destructive lesion of the kidney and no pressure necrosis of the ureter or pelvis by a stone.[24] But we feel that, by strict definition, these additional criteria are unduly rigid.

Spontaneous extravasation has been reported to be due to an obstruction by ureteral stone,[20] and by tumor.[23] Herein, we report a very interesting case where spontaneous extravasation was initiated by ureteral stone and perpetuated by acute edema of the ureteral orifice following basket extraction of the stone. A thorough search of the literature did not reveal any previous reports of its kind.

Case Report

A 35-year-old, white, female patient was first seen a week prior to admission with right ureteral colic. An intravenous pyelogram showed a non-obstructing stone in the right upper ureter. Despite symptomatic treatment she returned with recurrence of severe colic. There was marked tenderness in right costovertebral angle and right lower quadrant. Temperature was normal, pulse 60 per minute and blood pressure 140/90 mm. mercury. SMAC profile was normal. An emergency intravenous pyelogram showed the stone in lower ureter causing obstruction (Figure 1). There was also early extravasation of urine into the peripelvic area.

We felt the stone was probably too big to pass spontaneously and so basketed it the next day. It was a calcium oxalate stone measuring seven x four mm. But she continued to have pain and tenderness in the right costovertebral angle and remained nauseated. After two days she became acutely ill and developed persistent vomiting. Her temperature rose to 101° F, pulse was 106 per minute and blood pressure 170/100 mm. mercury. The abdomen was distended with a very marked tenderness in right costovertebral angle. Urine culture on admission was reported sterile. Since a residual stone was suspected, an intravenous pyelogram was repeated (Figure 2). There was no evidence of any stone, but the entire upper collecting system was distended down to ureterovesical junction. The peripelvic extravasation had markedly increased. In short, the clinical picture was one of acute ileus, pyrexia and increasing peripelvic extravasation.

The patient was treated conservatively with nasogastric suction, parenteral fluid replacement and antibiotics. The response to treatment was dramatic. After a week she was asymptomatic and blood pressure was 140/90 mm. mercury. A repeat intravenous pyelogram after one month

Figure 1. Intravenous pyelogram showing hydroureteronephrosis on the right side down to the obstructing calculus near the ureterovesical junction. There is early accumulation of peripelvic extravasate.

was much improved (Figure 3). After 18 months she remains normotensive and free of stone disease.

Discussion

Pathophysiology. With ureteral obstruction there is an increase in intrapelvic pressure which triggers various routes of backflow (schematically constructed in Figure 4). Fundamentally, the urine either enters the tubules or the fornicial regions. It has been shown that the epithelium of the calyceal recesses has the ability to resorb urine and that the urine removed from a calyx differs from the urine in the ureter.[25] With increasing intrapelvic pressures there is an increasing demand on the routes of backflow. Whether there is anatomical rupture of the fornices or rupture of the overburdened lymphatics is not clear. The urine then enters the venous plexus around the fornix or tracks along the renal sinus into the retroperitoneal space around the renal pelvis. From here it is ultimately absorbed by the lymphatics. Occasionally, the peripelvic collection may persist to form a cyst or urinoma,[23,24] or may even be infected to form a perinephric abscess,[15,24] or may be organized to result in retroperitoneal fibrosis.[11]

Reports on manometric studies on this subject are conflicting. Extravasation has been documented by increasing intraureteral pressure by applying extrinsic compression during intravenous urography[12] and during retrograde pyelography.[2] Experimental data shows a wide range of intrapelvic pressures required to initiate a backflow. On retrograde studies, Kohler[2] recorded initiating pressures of 100-130 cms. of water, while Ross[3] recorded pressures as low as 20 cms. of water. Ross also observed that average pressures were slightly less in cases with backflow than in those without backflow. Radioactive experiments also show similar variations. Risholm & Obrink introduced albumin labeled with ^{131}I into a closed renal pelvis and detected radioactivity in blood samples at pressures of 15 to 20 cms. of water.[26] Infusing radioactive diodrast into a closed renal pelvis, Dominguez and Adams detected diodrast activity in the femo-

Figure 2. Intravenous pyelogram showing dilatation of the upper collecting system down to the ureterovesical junction. Increasing accumulation of peripelvic extravasate is seen tracking down the renal hilum from the calyceal fornices.

Figure 3. Intravenous pyelogram showing much improved upper collecting system, with complete resolution of the peripelvic extravasate.

ral vein at about 260 cms. of water pressure.[27] And yet, a pressure of 150 cms. of water has been shown to be sufficient to cause experimental rupture of the renal pelvis.[29,30] It appears, therefore, that spontaneous extravasation is an unpredictable event. Kiil found, however, that the rate of increase in pressure was a more important factor than the absolute rise.[28]

Diagnosis. Clinically, small extravasations in the peripelvic area are usually missed and are mistaken for signs and symptoms of an obstructed kidney. Larger accumulations present a more violent picture. There is marked tenderness in costovertebral angles and a mass may be palpable. Fever may be present. Gastrointestinal symptoms are pronounced and may simulate intestinal obstruction. Patients with actual rupture of renal pelvis or ureter are more ill. It may be difficult to differentiate from acute abdominal inflammations (appendicitis, cholycystitis, pancreatitis, and diverticulitis), perforation of abdominal viscus (perforated ulcer, perforated gall bladder, and perforated diverticulum), ischaemic bowel disease and dissecting aortic aneurysm.

Radiological appearances are characteristic. On an intravenous pyelogram psoas shadow is usually blurred due to peripelvic extravasate. On close scrutiny the contrast material is seen around a calyx leaking through a fornicial rupture and tracking down the renal hilum into the peripelvic area. The ureter is usually well visualized except in cases of frank rupture.[24]

Spontaneous extravasation is probably rare,[14,18] but with the use of emergency intravenous pyelography in the investigation of ureteral colic, it may be seen more frequently.[24] Schwartz *et al* reviewed all intravenous pyelograms made during acute urinary colic attacks and reported some blurring of the psoas shadow in approximately 50 per cent of them.[24] It appears likely that some degree of extravasation does occur relatively frequently. Such a conclusion is also supported by the appearance of "wet" retroperitoneal space often found on exploration after an attack of acute renal colic.[11]

Extravasation may occur very early during a colicky episode.[24] It is usually transient and

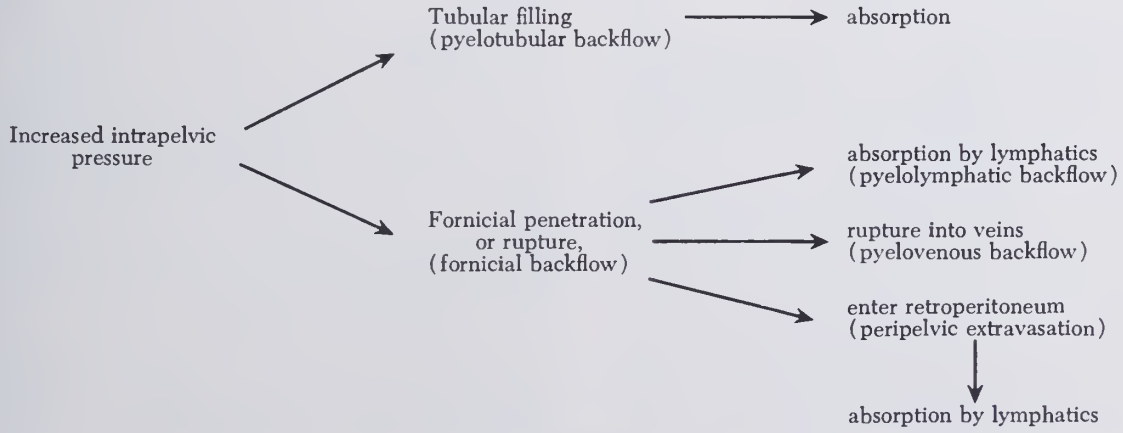

Figure 4. Schematic representation of ultimate routes of backflow after ureteral obstruction.

lasts one to two days; but, in actual rupture of the pelvis or ureter it persists much longer.[20] There are exceptions, however, and spontaneous extravasation may also persist for seven to 10 days.[21] In cases of doubt a cystoscopy and retrograde pyelogram may clarify the site of extravasation.[20,24]

Management. It is very important to distinguish spontaneous extravasation of urine from a true rupture of the pelvis or ureter. A true rupture requires immediate surgical intervention.[20,24] Spontaneous extravasation, however, can be treated conservatively in most cases.[24] It is usually transient and disappears with the passage of the stone.[24] In our case, we felt the stone was probably too big to pass spontaneously and so resorted to basket extraction. A post-extraction intravenous pyelogram did not show any extravasation at the ureterovesical junction, excluding the possibility of iatrogenic tears. Yet, there was increasing extravasation around the renal pelvis. It seems the acute edema of the ureteral orifice was sufficient to perpetuate the peripelvic extravasation. Confident of the transient nature of this edema, we treated the patient conservatively. Indeed, a repeat intravenous pyelogram after one month shows much improvement. Had we not basketed the stone, the course of extravasation might have been more distractful.

Schwartz *et al* have suggested that extravasation in itself is not an indication for any specific therapy;[24] however, we feel that one cannot make such generalizations. Every case of extravasation should be judged in relation to the nature of obstruction. If the obstruction is transient, extravasation might be no more than a mere historical event. A persistent obstruction calls for surgical interference. The need for adequate follow-up to insure complete resolution of extravasation cannot be over-emphasized.

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Treatment Of Localized Carcinoma Of The Prostate By Implantation Of Radioactive Iodine-125 Combined With Bilateral Pelvic Lymphadenectomy

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Radiotherapy has demonstrated its effectiveness in control of prostatic carcinoma. A technique of retropubic implantation of I^{125} seeds combined with bilateral pelvic lymphadenectomy in 27 patients with selected prostatic cancer is presented. The method is technically simple, has permitted delivery of potentially effective irradiation to the prostate, has had no associated mortality and only minimal morbidity, and has produced only minimal disturbances in urinary, rectal, and sexual functions. This procedure has produced an encouraging degree of local regression in clinically-evident prostatic lesions over a brief period of follow-up.

INTERSTITIAL radiation therapy in prostatic carcinoma was first used by Pasteau and Degrais,[1] in 1909, in Paris, France, by using intraurethral radium capsules. In 1915, Barringer,[2] at the Memorial Hospital in New York, treated prostatic carcinoma by inserting radium needles into the gland. In 1951, Flocks and Associates[3] introduced injections of colloidal solution of radioactive gold into the prostate. Each of the above procedures resulted in undue side effects. In 1970, Whitmore and Associates[4] introduced Iodine-125 as a substitute for radon 222 or gold 198, and he has used it extensively in interstitial implants in prostatic carcinoma with minimal complications.

Iodine-125 is available in the form of seeds measuring only a few millimeters and is available in different strengths of 0.40 to 0.95 millicuries. It has a half life of 60 days and emits a very soft gamma energy of 28 keV. The intensity of this gamma radiation is reduced to half by only a two-cm. block of soft tissues, while seven to eight cm. of tissue can reduce the intensity to less than 10 per cent.[5] Iodine-125 has a higher therapeutic ratio than with radon and other radioactive nuclides. This is due to sustained continuous low dose of radiation to the malignant cells resulting in high relative biological efficiency. This has been proved on several cell cultures *in vitro* and *in vivo*. Even hypoxic cells, which are responsible for treatment failure, respond well to sustained, continuous radiation.[6]

Carcinoma of the prostate has a very slow growth rate and often remains localized for long periods. Therefore, prostatic carcinoma of stages A, B, and early stage C lesions are suitable tumors for permanent implantations. Stage A carcinoma is clinically unrecognizable, but where more than three microscopic fields were involved with tumor following prostatic surgery. Stage B carcinoma is a palpable nodule or induration confined within the prostatic capsule, and an early stage C carcinoma is induration extending beyond the prostatic capsule, but less than six cm. in diameter. The radiation dose can be more accurately adapted to tumor size and shape. A dose of 15,000 to 20,000 rads can be accurately delivered to the prostate in one year[7] with less dosage to the rectum and bladder (10 to 15 per cent only). Since Iodine-125 seeds have a very low energy, the hazard of undesired radiation exposure to patient and personnel is minimal.

By using supervoltage radiation, the adjacent tissues, such as bladder and rectum, receive a dose in the range of 65 to 70 per cent, resulting in complications.

Technique

The Iodine-125 seeds are inserted into the prostate via the perineum and retropubic approach. We have preferred a combination of the perineal and retropubic approach in order to get optimum dose in and around the prostate gland with least morbidity and much greater accuracy. A pelvic lymph node dissection is performed to more accurately stage the disease. The lymph node dissection is begun at the level of the common iliac artery bifurcation, and continued distally along the external iliac vessels to Poupart's ligament. The obturator fossa is dissected, preserving the obturator nerve, but usually removing the obturator vessels with the obturator nodes.

Following the lymph node dissection, the fat covering the anterior surface of the prostate is removed, exposing the prostatic capsule. Hollow stainless steel needles of 16-gauge and 15 cm. in length are inserted into the prostate until their tips can be sensed by the palpating finger in

the rectum. The needles are placed parallel to each other and spaced 1 cm. apart. The seeds are introduced through the needles by using a Mig gun.[8] The instrument has a magazine, which automatically delivers the seeds, and a ratchet mechanism for insertion of the seeds into the tissue at intervals not less than 0.5 cm. apart. Metallic clips are placed around the surface of the gland to facilitate dosi-metric calculation. The surgical incision is closed, leaving a Penrose drain.

Materials and Results

This procedure was started two years ago at the West Virginia University Medical Center and has been used in 27 patients. In all patients, clinical evidence of metastasis from physical examination, serum acid and alkaline phosphatase, bone scan and intravenous urogram were absent at the time of operation. All patients had a tissue biopsy documenting the evidence of prostatic cancer. Liver scan, bone marrow aspiration, and cystoendoscopy were also done as part of the staging procedure. If there was sufficient bladder outlet obstruction from prostatic cancer or associated benign disease, a conservative transurethral resection was performed. However, sufficient tissue was left to support an implant. Six weeks were allowed for healing before performing the implantation.

Three patients had clinical stage A lesions with negative lymph nodes. Seventeen patients had clinical stage B lesions and two had positive lymph nodes. Seven patients had clinical stage C lesions and four had positive lymph nodes. In the 21 patients with negative lymph nodes, no further treatment was given. In the six patients with lymph nodes positive for metastasis, an additional 4,500 rads were administered to the pelvis by using cobalt-60 supervoltage.

After each insertion, steriographic x-rays of the pelvis were done, and computer printouts were obtained in order to calculate accurately the radiation dose to the prostate, rectum, bladder and para-prostatic tissues. The prostate received an average dose of 18,000 to 20,000 rads, while the bladder and rectum, calculated at a distance of 2.4 cm. to 3.0 cm from the periphery of the prostate, received only 2,000 to 5,000 rads in one year. This dose is well within tolerance. The average number of seeds implanted into the prostate gland ranged from 25 to 30, with an average strength of 0.60 to 0.70 millicuries.

In general, the operative procedure was well tolerated, and the average hospitalization, postoperatively, was between eight and 10 days. Postoperative complications were minimal, with four patients having minor degrees of suprapubic wound infections. Radiation complications have been minimal, with three patients having mild rectal bleeding which subsided without any treatment. Two patients had minor degrees of urethritis, relieved by pyridium. In patients who claimed potency preoperatively, all but one claimed postoperative potency.

Based on rectal examination one year later, the size and/or induration of the prostate was thought to have been reduced in the majority of patients. Of 10 patients who were rebiopsied one year later, eight had no tumor in the rebiopsied specimen.

Discussion

Adjunct endocrine therapy has been used (one milligram of diethylstilbestrol daily) in patients with positive lymph nodes, and in patients who had positive biopsies one year later. Diethylstilbestrol may alter the tumor cells and, by shrinking the prostate, increase the effectiveness of the declining irradiation by bringing the I-125 seeds closer together.

The operative technique also provides a method to check on the accuracy of clinical staging and has confirmed the relatively high incidence of lymph node metastases from clinically non-metastatic prostatic cancers.

All but one patient are alive. The one exception died nine months postoperatively from a myocardial infarction. A detailed analysis of the follow-up of these patients relative to the prostatic cancer is not warranted at this early date. In 208 patients treated by I-125 interstitial implantation and bilateral pelvic lymphadenectomy, Doctor Whitmore reports that 92 per cent of the patients with histologically negative lymph nodes were alive at five years, compared to the 46 per cent of the patients with histologically positive nodes.[9]

Summary

The advantages of no associated mortality, minimal disturbances in urinary, rectal and sexual functions, more accurate tumor staging, and the means whereby the radiation dosage can be better adapted to an irregular tumor shape, may make this procedure more ideal than either radical prostatectomy or external radiation therapy in treating localized carcinoma of the prostate gland.

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Behavioral Therapy Aids Obese Children

BEHAVIORAL therapy offers new promise in helping obese children to get rid of the excess pounds, according to a report in a recent issue of American Journal of Diseases of Children.

Obesity is one of the most refractory health problems facing the physician today, state Drs. Kelly D. Brownell and Albert J. Stunkard of the University of Pennsylvania Medical School, Philadelphia.

The doctors report on experimental studies in teaching behavior modification to children to help them lose weight.

Children keep daily logs of what they eat, and estimates of its caloric content. Children are seated at different tables, where they are served low-calorie, nutritionally-balanced meals. They are taught to slow down the rate of eating by such methods as putting down the utensils between bites.

The central element in behavioral weight control is slowing the rate of eating. Slower rate helps obese people to control their food intake, said Doctors Brownell and Staunkard.

Rhabdomyoma Of The Heart: Case Report Of A Rare Cardiac Tumor Associated With Polyhydramnios

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Rhabdomyoma is an extremely rare, primary cardiac neoplasm. It is, however, the most common primary heart tumor in infancy. Although electron microscopy indicates uncertainty in the histogenesis, it is concluded that ultrastructural characteristics common to both Purkinje and myocardial fibers are present.

A case of cardiac rhabdomyoma in a stillborn baby associated with polyhydramnios in the mother is presented. A review of the literature reveals that most babies so afflicted are born alive, that diagnosis may be made by newer, sophisticated procedures, and that surgical removal is possible. Prognosis is, however, poor.

TUMORS of the heart are extremely rare, with primary tumors being even more so. In some reports, no tumors of the heart have been recorded in as many as 30,000 autopsies, while in other studies as many as three cases of primary tumors were reported in 1,200 autopsies (0.25 per cent).[1] According to American Medical Association statistics, 480,331 autopsies were performed in the United States from 1938 to 1942. During this period, reports of eight cases of primary tumors of the heart were published for an overall incidence of 0.0017 per cent, assuming that all cases were reported.[2] Ravid and Sachs, in 1943, reported an incidence of 0.05 per cent.[3] At the Winnepeg General Hospital, Winnepeg, Canada, during the period 1937 to 1947, 648 nonviable fetuses (1.4 per cent) of all surgical pathology specimens were examined, with only one case of cardiac neoplasm reported. From 1916 to 1947, in the same hospital, of the 6,275 autopsies performed, 509 were on viable fetuses and newborns, with only one primary tumor of the heart recorded.[4]

Case History

A 21-year-old, white female, gravida one, was admitted on March 7, 1974, because of two-plus pitting ankle edema, albuminuria, rapid increase in body weight and rise in blood pressure. This was associated with rapid increase in the height of the uterine fundus. Forty-one days prior to admission, her blood pressure was 120/70 mm. of Hg. and the height of the uterine fundus was 27 cm. above the symphysis pubis. This was her first prenatal visit and her EDC was calculated to be April 4, 1974.

On her second prenatal visit, 14 days prior to admission, her blood pressure was 140/100 mm. of Hg., there was two-plus pitting ankle edema, and height of the fundus was 42 cm. The possibility of the diagnosis of twin pregnancy or polyhydramnios was entertained. A 30-pound increase in body weight was also noted on this visit. The urine showed one-plus albuminuria. One day prior to admission, the patient experienced considerable difficulty in breathing.

On admission, x-ray pelvimetry showed a single, third-trimester fetus with legs and arms widely spread apart. This was considered compatible with polyhydramnios. Pelvic bony measurements were considered normal. Blood chemistry and hematological studies were unrevealing. Urinalysis was unremarkable. Fetal heart beats were present.

Shortly after admission, premature rupture of the membranes occurred, initiating labor. Considerably more than the usual amount of amniotic fluid was lost following rupture of the membranes. During labor, fetal heart beats were heard; however, under general anesthesia and following an episiotomy, a stillborn baby was delivered by low forcep manipulation, necessitated by dystocia due to weak contractions.

Pathological Features

The most significant aspect of the autopsy centered upon the heart, which weighed 100 grams. Externally, a bulge was noted on the anterior surface, while the great vessels arose in the usual fashion. On section, a well circumscribed, bulging, dull yellow tumor mass measuring 2.5 cm. was seen in the antero-septal wall of the left ventricle. It extended from the apex to the base up into the interventricular septum (Figures 1 and 2). The endocardium showed marked loss of transparency, opaqueness, and thickening.

Histologically, the tumor consisted of large, vacuolated cells with small, irregular nuclei. This gave the tumor a spongy appearance. There were delicate cytoplasmic strands connecting the nuclei and cellular borders to give the so-called "spider-like" architectural pattern. The phosphotungstic acid-hematoxylin stain showed typical cross stri-

Figure 1. Serial sections through heart showing tumor in antero-septal wall of left and right ventricle.

ations in the cytoplasm (Figures 3 and 4). These findings were considered consistent with rhabdomyoma.

Comments

At present, there have been a few more than 100 cases of cardiac rhabdomyoma reported in the literature.[5] The first reported case of rhabdomyoma of the heart appeared in 1828, according to Kolisko,[6] who noted that Billard,[7] in "Traite des maladie des enfans noveau nes et a la mamelle," published in Paris, described a case of multiple congenital rhabdomyoma of the heart. In this case there were three small tumors in the anterior wall of the left ventricle and interventricular septum in a three-day-old infant.

Authentic cases were also reported by Von Recklinghausen,[8] in 1862, Kolisko,[6] in 1887, and Hlaya,[9] in 1896. In 1900, however, Seiffert[10] reviewed all nine reported cases of rhabdomyoma and rejected cases reported by Kantozow, Virchow, Skorzeczka, Rieder, and Yusti.

Ponfick,[11] in 1901, noted the association of cardiac rhabdomyoma with tuberous sclerosis in

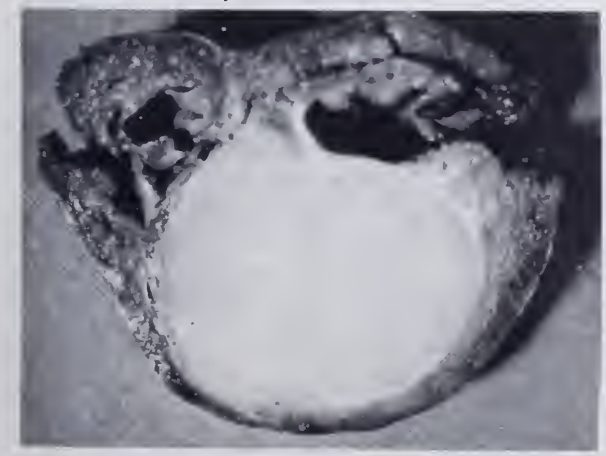

Figure 2. Well-circumscribed opaque tumor mass of antero-septal wall involving a good part of the interventricular septum.

Figure 3. Low power of tumor mass, showing the spongy appearance.

two cases. Prior to 1907, only two cases were even reported in the American medical literature. Farber,[12] in 1931, collected a total of 41 cases reported in the medical literature at that time, only three of which were in the United States. Pritchard,[13] while conducting an extensive review of the literature in 1951, discovered 70 cases.

Rhabdomyoma is the most common primary cardiac 'tumor' in infancy.[14] There has been much speculation on the histogenesis of cardiac

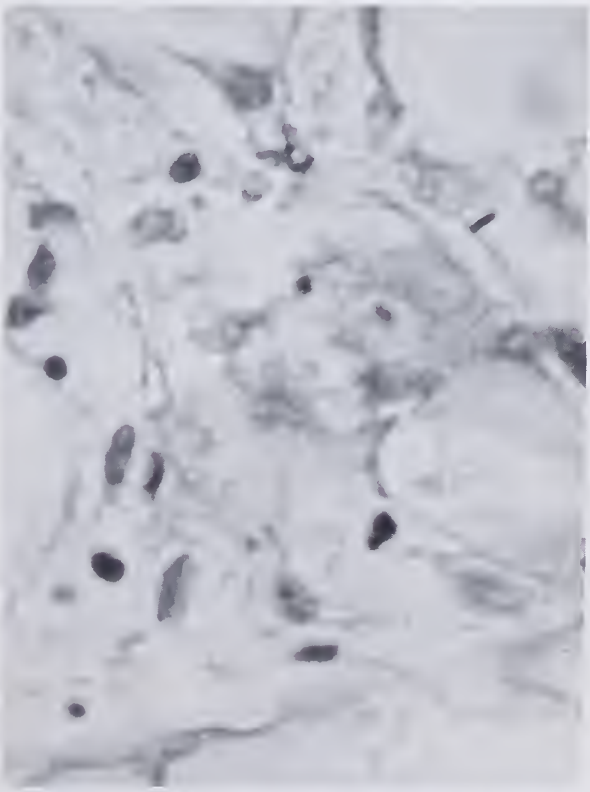

Figure 4. High power of tumor, showing typical "spider cell."

rhabdomyomas. It has been suggested that it is either a neoplasm, a hamartoma,[15] a form of glycogen storage disease,[16] or gigantism of myocardial fibers.[18]

The first electron microscopic study was carried out by Silverman[5] *et al* at the Medical College of Virginia. The conclusion of that study was that the exact histogenesis was still uncertain, although it was noted that origin from two types of fibers was possible. Although their studies did not settle the issue of rhabdomyomic origin from the Purkinje cells[17] or from a primitive layer common to both the Purkinje and myocardial fibers,[12] they did find ultrastructural characteristics of both Purkinje and myocardial fibers.

Below Age Of Three

Most rhabdomyomas discovered are in children below the age of three.[12,18] In Farber's[12] studies, 12 of 41 cases were older than three years of age, with the oldest being 35 years old. In 63 cases studied by Batchelor and Maun,[18] 42 were under three years of age. Steinbiss[19] reported a patient 37 years of age in 1923. The oldest patient reported to have the classical lesion was a 45-year-old woman, reported by Lymburner.[20] Clinically, these tumors may be suspected in patients who have abnormal cardiac symptoms or signs when associated with tuberous sclerosis.

In Batchelor and Maun's studies,[18] the incidence of associations with tuberous sclerosis was 50 per cent. Kidney tumors, angiomyosarcomas, angiolipomas, cysts, nest of embryonal tissue, various malformations, and adenomas, especially sebaceous adenomas, are frequently encountered in patients with rhabdomyomas. Electrocardiographic studies, cardiac catheterization, and angiocardiography are helpful in the diagnosis. More sophisticated procedures such as cineangiography and echocardiography may reveal more pertinent findings. In Silverman's studies,[5] angiograms and cineangiograms revealed filling defects in the ventricular chambers, and clusters of echoes were picked up on the echograms in the vicinity of the filling defects. These procedures are also helpful in following the patient's course after surgical removal of the tumor, since the abnormal filling defects and echoes disappear, as in Silverman's cases.

Prognosis Poor

Despite successful surgical removal of these tumors, the prognosis is very poor. Usually, according to one study, only 15 per cent of patients live beyond the age of five, with death occurring due to cardiac arrhythmias, mechanical interference, or from complications of other associated diseases, especially tuberous sclerosis. Surgical intervention is recommended only for those without evidence of tuberous sclerosis or mental deficiency.

Our case is a solitary rhabdomyoma not associated with any other congenital malformation. Its size and position, however, in my opinion, were the two factors responsible for the demise of this baby, in addition to intrauterine cardiac failure of the baby as the direct cause of death. The polyhydramnios has to be associated with the cardiac decompensation in the baby.

In review of the literature, no cases associated with polyhydramnios could be found. Most babies with congenital rhabdomyoma are born alive and are usually diagnosed in the newborn period, infancy, or childhood. All 41 cases of Farber[12] were born alive. The rhabdomyoma reported by Leach[4] was a stillborn, 26-week-old fetus whose mother presumably had premature separation of the placenta.

We believe this case to be the first instance of congenital rhabdomyoma with associated polyhydramnios and stillbirth.

Acknowledgements

The author wishes to express his thanks to the following people for their help in the preparation of this manuscript: Dr. Linda De La Pena, Pathologist, Veterans Administration Hospital, Clarksburg, West Virginia; and Kay Sprouse, Secretary, United Hospital Center, Inc., Clarksburg.

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Drop Radical Mastectomy, Experts Say

RADICAL mastectomy for breast cancer does not increase survival compared to more conservative operations and should be abandoned except in special circumstances, according to a report in a recent issue of Archives of Surgery, a scientific journal of the American Medical Association.

"The question of what operation to use in the treatment of cancer of the breast has long been debated," say a team of Rockford, Illinois, specialists.

Drs. Alfred C. Meyer and Simmons S. Smith of Rockford School of Medicine and Ms. Meredith Potter of Rockford College have surveyed all women operated on in Rockford for breast cancer from 1924 to 1972 who could be followed for at least five years after surgery. Most of the patients were followed for 10 years, or until death.

Many different surgeons were involved, and each used the type of operation he thought best. Some were radical mastectomy, some simple mastectomy, some modified radical mastectomy and a few simple removal of lumps.

"An analysis of 1,686 surgically-treated carcinomas of the breast in one community showed no statistically significant differences in five- and 10-year survival for simple, modified radical, or radical mastectomy," the researchers conclude.

Leiomyosarcoma: A Case Report*

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A case of leiomyosarcoma in the retroperitoneal area presented initially with the chief complaint of epigastric abdominal pain. Roentgenographic findings revealed a left upper quadrant mass, and arteriogram illustrated an avascular mass which was interpreted as a possible pancreatic cyst. Exploratory celiotomy revealed an unresectable retroperitoneal mass with a histological diagnosis of leiomyosarcoma. The patient responded to cobalt radiation with regression of tumor size, as confirmed by exploratory surgery performed three months after the initial operation. This regression of tumor size has been maintained with chemotherapy.

LEIOMYOSARCOMAS are uncommon tumors of the gastrointestinal tract.[1,2,7] These tumors are difficult to diagnose. Physical and clinical findings are usually vague and roentgenographic findings often non-specific, demonstrating the mass only by contrast x-ray.[4] Therefore, when the diagnosis of leiomyosarcoma is made, the tumor is often already widespread and the prognosis usually dismal.

Case History

A 49-year-old, white female was admitted to the United Hospital Center, Inc., at Clarksburg, West Virginia, with the complaint of epigastric abdominal pain radiating to the back of about six months' duration. The pain was described as vague discomfort in the left upper quadrant. She had also experienced diarrhea, with three to four bowel movements per day, and intermittent nausea. History revealed that about four years prior to admission she had sustained abdominal trauma and fracture of the lumbar vertebrae. Over the past four months, the patient had lost about 10 pounds. Previous surgery included excision of a left ovarian cyst with incidental appendectomy in 1952, and a cholecystectomy with other normal findings to exploration in 1973.

On physical examination, palpation revealed a firm mass about three fingerbreadths below the left costal margin. Laboratory evaluation disclosed a normal chemical profile except for elevation of serum calcium; CBC was normal. Barium enema (Figure 1) revealed extrinsic pressure at the hepatic flexure of the distal portion of the transverse colon. The stomach (Figure 2) was displaced anteriorly and medially, leading to the interpretation of a possible pancreatic cyst or a mass in the tail of the pancreas. Celiac arteriogram (Figure 3) showed splenic artery displacement, which appeared to be due to a nonstaining avascular mass in the body and tail of the pancreas, suggesting a pancreatic cyst. Liver and spleen scans were normal.

Exploratory celiotomy was performed on December 4, 1975. This revealed a retroperitoneal mass about 12 cm. in diameter located below the stomach and above the colon; also, the pancreas was to the right and a normal-size spleen was located posteriorly. The mass was solid, with marked vascularity, and firmly attached to the retroperitoneal area. There was no evidence of metastasis. A biopsy of the tumor

Figure 1

*This paper was written while Doctor Lawse was a Resident in Family Practice at the United Hospital Center, Inc., Clarksburg, West Virginia.

Figure 2

revealed leiomyosarcoma. Prior to closure the tumor was marked with silver clips at the boundaries over an oblong area approximately 12 cm. in length and 10 cm. in diameter. The patient's postoperative course was unremarkable. Following discharge, she was referred to West Virginia University Medical Center at Morgantown for radiation therapy. External radiation with Cobalt 60 was administered, with total dosage of 5,000 rads in 34 days to the tumor area. On March 1, 1976, a celiotomy for possible tumor excision and biopsy for chemotherapy revealed regression of the tumor mass to six centimeters in diameter. The area was very vascular with fibrotic changes

Figure 3

and the tumor was non-resectable because of adherence to vital organs. Deeper wedge biopsy of residual tumor consisted of a necrotic area with hard yellowish material and spindle-shaped, malignant-looking cells demonstrating residual leiomyosarcoma. The patient was treated with 90 mg. of Adriamycin IV, and has had no further progression of tumor size. One year after the initial diagnosis, the patient remains stable, living a fairly normal life as a housewife.

Discussion

Leiomyosarcoma is a slow-growing tumor with a slow rate of metastasis. These malignant tumors are difficult to diagnose due to vague clinical symptoms and non-specific roentgenographic findings. Surgery is the preferred therapy, but because diagnosis is difficult, the disease is often far advanced and the tumor found to be unresectable, resulting in a dismal diagnosis.

The average age of incidence is between the second and fifth decade, with no sex predilection reported.[3] Duration of symptoms varies from one to six months, with common symptoms of abdominal pain, change in bowel habits, anemia or bleeding, and palpable abdominal masses. Available data illustrates that developing leiomyosarcomas have a slow rate of growth and that metastasis is slow to develop. The prognosis is greatly improved when the tumor is detected early, with total tumor mass excision preferred when this is feasible. No favorable results have been reported from radiotherapy or chemotherapy.[3,5,7]

Diagnosis of leiomyosarcoma is rarely made prior to operation.[8] Histological examination reveals spindle-shapped cells with malignant-appearing nuclei and mesenchymal elements; cells having extremely long, fiber-like cytoplasms and hyperchromatic nuclei; and large, anaplastic malignant cells having nuclei with nucleoli and mitosis.[1]

The clinical presentation in this case and in other reported cases emphasizes the symptom of vague abdominal pain of several months' duration.[8] Other symptoms are also vague. Roentgenographic findings are the only clues to the abdominal mass and may be misleading, with a definitive diagnosis obtained only by biopsy at the time of surgery.

A review of the literature discloses poor response to radiation and chemotherapy.[3,5,7] This case is unusual in that there was a remarkable response initially to radiation, as demonstrated by the exploratory celiotomy following the radiation therapy. Chemotherapy with Adriamycin IV prevented further progression of the tumor.

Acknowledgement

The authors are indebted to John D. H. Wilson, M. D., radiologist at United Hospital Center, Inc., for his comments.

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Manuscripts to be presented for publication in *The West Virginia Medical Journal* should be typewritten, triple-spaced, on one side only of firm (no onion skin or flimsy), standard letter sized (8 1/2 by 11 in.) white paper. Wide margins (at least 1 1/4 in. on left) should be left free of typing. On the first or title page should be shown the title of the article, the name (or names) of the author, and his degrees. Pages should be numbered consecutively, the page number being shown in the right upper corner along with the surname of the author.

Where reference is made to generically-designated drugs, the first such reference must be followed by parentheses containing the most commonly known trade-name drug of that designation. In addition, a listing of all generic drugs mentioned in the article, with their trade-name equivalents, should appear at the end of the article.

A short abstract summarizing the manuscript should be included. This should be typed in double space on a separate page.

Authors are requested to submit a carbon copy with the original.

Illustrations should be numbered and their approximate locations shown in the text. Each should be identified by placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for reproduction should be done in black (India) ink on pure white. Photographs should be on glossy paper and minimum of about 5 by 7 in. in size. A legend should be provided for each illustration and, preferably, attached to it.

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A message from . . .

The President

IT'S TRULY BEEN GREAT!

HELEN and I are near the end of one of the busiest assignments of my Presidential Year—our visits to component, and to other state, medical societies and associations.

I'm certain no President undertakes his tour of the local societies without some hesitancy. Just who are those physicians who play active roles in medicine in their own communities? What do they expect of their State Association and its President? How can one best convey what the Association is trying to do in the face of problems and challenges it sees for physicians? And perhaps most important, how can a President best draw from those physicians throughout the state their ideas, reactions and help?

I don't have firm answers to all of those questions, even after thousands of miles of travel since last August and countless hours of conversation and discussion. But Helen and I are convinced of one thing!

We have in West Virginia medicine the finest kind of people—interested, concerned, dedicated physicians and their families who make immeasurable day-by-day contributions to cities, towns and hamlets in which they live and practice.

The welcome, courtesy and understanding extended to us at every single stop on our long schedule of visits have been beyond description. There is no earthly way such hospitality and consideration can be repaid. But we can say one thing from the bottom of our hearts.

Thanks for everything, and it's truly been great!

JOSEPH A. SMITH, M. D., *President*

The West Virginia Medical Journal

Editorials

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author shall be held entirely responsible.

One way or another, it seems, there will be additional provider and consumer input as the state's Health Systems Plan undergoes hopefully continuous revision.

TRUE PLANNING MOST NECESSARY

To carry this thought one step further—there HAS to be more such input. The HSP and the accompanying Annual Implementation Plan (AIP) represent goals, and how to reach them, in setting forth a health system for West Virginia.

Much controversy developed as to whether there, indeed, was much real grass-roots thinking at all reflected in the initial HSP put together by the West Virginia Health Systems Agency, Inc.

The planners argue that there was, or that everyone at least had a chance to be heard. That's highly debatable, as witness an impressive array of comments, oral and written, which emerged before, during and after some five public hearings on the plan in late March and early April.

What did or did not happen as the plan first was put together is still important, but not as significant as what must take place now, and in the future.

Certainly in large measure because of a downright uproar from many sectors about nonparticipation in the planning process, the Health Systems Agency substantially modified the introduction to its initial plan with regard to general input and involvement.

"Much effort on the part of members, the Board of Directors and staff has gone into stimulating the involvement of all citizens of West Virginia in the activities of WVHSA (the planning agency) since its inception," the introduction now proclaims, in the very first sentence. It goes on to say:

"Hundreds have served actively on committees and task forces of the Board, and many others have attended public meetings of WVHSA. However, we have not yet reached the high level of involvement we consider desirable. The HSA feels responsible to continue and expand the involvement of consumers, providers, payors, and representatives of various levels of government. All must be made more aware of the Health Systems Agency and its important role in health care for West Virginia.

"In the coming year, continuing emphasis will be placed upon involving consumer and provider groups and individuals, as well as local governments. Particular attention will be given to involving representatives of interested groups and organizations on the committees and task forces that will affect them. Local concern and input into the HSA process is the keystone upon which WVHSA is built."

There's more, but one specific challenge is thrown out in all this material—put into the plan at the last possible minute, incidentally. It centers about a mandate that the HSA's Plan Development Committee determine what task forces and ad hoc advisory groups are necessary to initiate or complete required actions consistent with the HSP/AIP.

It continues with a further, related mandate—the Committee "shall request from the appropriate professional groups or associations (such as the Medical Association and its component societies) a list of names for appointment to needed ad hoc groups. . ."

In other words, the plan in effect is telling providers (including physicians) and others to "put up or shut up." And the state's physicians, who must take every possible step all the way to assure they can provide effective care for the general public, must "put up."

Dr. Joseph A. Smith, the Medical Association's President, is urging doctors to do just that—to make themselves available, through their component society secretaries, for nomination for service on HSA committees at the state and local levels.

Those working within the HSA structure have some work to do, too. They've got to learn, in a number of instances, to approach physicians and others and ask for their help. That was not done too well in the first stages of plan development.

In other words, implementation of what stands as a federal planning law is going to require maximum effort from many directions. Physicians should not be found wanting in any part of a really constructive process.

FREE MARKETPLACE CHOICE NEEDED

The AMA-created National Commission on the Cost of Medical Care has opened up a new horizon by emphasizing the need to restore the concept of free-marketplace choice in health-care delivery.

What does that mean?

Well, picture the delivery system as a marketplace where producers and consumers handle their transactions through insurers, private and public. The Cost Commission report recommends that producers and consumers have direct impact on decisions made in their behalf.

Consumers want to buy services at a lower annual rate of cost growth than the 11 per cent it has averaged since 1966.

However, the marketplace right now is not functioning well. It was flexible in the days when consumers paid the producer directly. But the patterns of coverage offered by today's middleman insurers are largely standardized in benefits and therefore in costs.

The Cost Commission report suggests ways in which those patterns can be stimulated to offer a latitude and freedom of choice.

For instance, employees could choose among health-care plans in terms of premium price, whereas employer contributions to premiums would be the same for any plan. The employee selecting a plan less expensive than the employer contribution would either be reimbursed for the difference or receive additional benefits.

The report makes this general observation:

"Reliance on market mechanisms can lead to cost-effective production of output, and permit consumer preferences to play a key role in determining what goods and services are available."

Unfortunately, this leeway cannot control costs all by itself. Nor does the marketplace assure care to the poor and uninformed, and their health-care costs could continue to rise sharply.

Hence, there must be some reliance on provider self-regulation and on local regulation if the overall tab is to be kept in line. No federal controls are recommended by the report.

Self-regulation would include cost-containment initiatives in the private sector of care, among third-party payers, and in medical practice. . .

The chief value of the report is that it brings many ideas and groups together in a coordinated program for genuine action. Some of the ideas are old, but have never been implemented. Group responsibilities include those placed on the consumer.

The upshot could be a momentum that would head off arbitrary, unwieldy federal formulas for cost containment. Developed after a year and a half of intensive study and efforts, the Cost Commission report presents credible alternatives to those formulas.—*Guest editorial by the American Medical Association.*

MORE PARTICIPATION NEEDED IN HOUSE

The dates are August 23-26. The occasion is the 111th Annual Meeting of the West Virginia State Medical Association at the Greenbrier. A component of that meeting centers about two sessions of the Association's House of Delegates. And that brings us to the point of these few paragraphs.

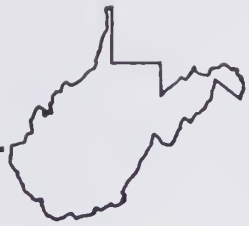
In recent years, at least, some component societies—and thus some West Virginia physicians—have not been represented in House deliberations because delegates and alternates designated by those societies have not been present.

With all of the challenges facing physicians, and most important the people of this state and nation as far as the future scope and quality of their health care is concerned, it's most important that the House and this Association represent the physician and public interest.

We're hopeful that we'll see a trend reversal this year, and that ALL component societies will have voting representation at the Greenbrier. The components have, or soon will, complete election of their delegates and alternates. It goes without saying that those local societies must consider the availability and interest of physicians in these selections.

There's no better, nor more important, vehicle for grass-roots participation in establishing positions on issues of the times.

GENERAL NEWS



AMA President To Speak At Annual Meeting

Dr. Tom E. Nesbitt of Nashville, Tennessee, who will be installed this month as President of the American Medical Association, has accepted an invitation to speak during the 111th Annual Meeting of the West Virginia State Medical Association to be held August 23-26 at the Greenbrier in White Sulphur Springs.

Tom E. Nesbitt, M. D.

The announcement was made by Dr. David B. Gray of Charleston, Chairman of the Program Committee.

Doctor Nesbitt, who will be installed as President during the annual convention of the AMA in St. Louis June 17-21, will address the first session of the House of Delegates on Wednesday afternoon, August 23.

He is in the practice of urology with seven other urologists in Nashville, and holds the academic appointments of Assistant Clinical Professor of Surgery, Urology, Vanderbilt University, Nashville, and Associate Clinical Professor of Surgery, Urology, Meharry Medical College, Nashville.

The AMA President Elect was a member of the AMA House of Delegates from 1967 to 1977, having served as Speaker from 1973 through July, 1977. He is a member (since formation in 1971) and former Chairman of the AMA's Coordinating Council on Medical Education, and also is a member of the National Advisory Council on Graduate Medical Education to the United States Secretary of Health, Education and Welfare.

Doctor Nesbitt is a member of the American Urological Association and a member and Past President of the American Association of Clinical Urologists.

A native of Mangum, Oklahoma, Doctor Nesbitt was graduated from the University of Tulsa (Oklahoma) and Louisiana State University, receiving his M. D. degree in 1948 from the University of Texas, Southwestern Medical College, Dallas. He completed postgraduate training at the University of Michigan in 1954, and was certified by the American Board of Urology in 1957.

Greenbrier Reservations Due By July 8

Reservations for the 111th Annual Meeting of the West Virginia State Medical Association should be made with the Greenbrier no later than Saturday, July 8, in order to comply with the hotel's requirement that all reservations must be received no later than 45 days prior to the meeting. Reservation forms provided by the Greenbrier have been distributed to all Association members. Any physicians who need additional forms should write or call the Association's headquarters office in Charleston.

Doctor Nesbitt is the author or co-author of some 20 scientific publications.

Annual Meeting activities will get under way with a 2 P.M. meeting of the Association's Executive Committee on Tuesday, August 22; the usual pre-Convention meeting of the Council at 10 A.M. on Wednesday, and the opening House session Wednesday afternoon.

Keynote Speaker

As announced previously, James A. Reynolds, Executive Editor of the widely read *Medical Economics* and a journalist known to many West Virginia physicians, will deliver the keynote, Thomas L. Harris Address at 9 A.M. opening exercises Thursday.

There will be two scientific sessions, the first to be held immediately following Mr. Reynolds' address on Thursday morning, and the other, on Friday morning.

A speaker for the Thursday morning "Symposium on New Methods of Treatment of Common Disorders," as previously announced, will be Dr. John W. Eckstein of Iowa City, Iowa, Dean of the University of Iowa College of Medicine. His topic will be "An Overview of Hypertension." Other Thursday speakers will be announced in a later issue of *The Journal.*

Friday Morning Session

Speakers for the Friday morning, August 25, scientific session, also announced previously, will include Drs. Edward E. Mason, also of Iowa City, Iowa, and Irvin M. Sopher of Charleston, Chief Medical Examiner, State of West Virginia. Doctor Sopher will speak on "The Medical Examiner System of West Virginia," while Doctor Mason, who is Professor of Surgery at the University of Iowa Hospitals, will discuss "Surgical Management of Obesity." Another Friday morning speaker will be announced later.

The Saturday morning, August 26, General Session, as previously announced, will be devoted to a program presented by Karen Zupko, Director of the AMA's Department of Practice Management. Ms. Zupko, a communications specialist, will discuss "Personnel: What You Need for Office Efficiency," and "Patient Relationships: Communications, Information, Rapport."

The general Convention format once again will provide opportunities for breakfast, luncheon and other meetings, of a scientific and/or business nature, of the various sections and specialty organizations affiliated with the Medical Association. It is anticipated that the bulk of these again will be scheduled on Friday (August 25).

Doctor Smith To Speak

Plans also call for the usual President's Reception on Wednesday evening, August 23, and the Saturday evening reception for new officers. The latter will follow the second and final House of Delegates session at 2:30 P.M. on Saturday which will bring the inauguration of Dr. Robert D. Hess of Clarksburg as President to succeed Dr. Joseph A. Smith of Dunbar. Doctor Smith will deliver his Presidential Address at the final House session.

The Annual Meeting of the Auxiliary to the State Medical Association, with Mrs. Joseph T. Mallamo of Fairmont in charge as the Auxiliary's President, again will run concurrently with the Association's Convention.

127th AMA Convention To Be Held June 17-21 In St. Louis

A number of West Virginia physicians will attend the 127th annual convention of the American Medical Association to be held June 17-21 in St. Louis.

The 1978 gathering will mark the end of the giant AMA annual summer meeting. After more than a century of big conventions, the AMA is

Richard E. Flood, M. D.

Frank J. Holroyd, M. D.

shifting emphasis toward multiple smaller sessions across the nation, aimed at providing continuing medical education for physicians.

Some 26 of the regional meetings are scheduled for 1979, offering physicians the opportunity to study on weekends, thus minimizing time away from their patients.

The AMA will continue to hold the annual winter scientific meeting each year. It will be in Las Vegas in 1978.

The program for the 127th convention was published in the April 21 issue of the Journal of the AMA.

The convention will offer physicians 55 continuing education courses covering the entire range of problems of diagnosis and treatment encountered by the doctors in their offices. Experts in each medical area will bring to the physicians the latest information on how to deal with disease.

In addition to the scientific programs at the St. Louis Gateway and Exhibition Center, the AMA's policy-making body, the House of Delegates, will convene at the Chase-Park Plaza Hotel for its bi-annual session.

The West Virginia State Medical Association's two Delegates to the AMA House of Delegates are Drs. Richard E. Flood of Weirton and Frank J. Holroyd of Princeton, with Drs. Harry S. Weeks, Jr., of Wheeling and Jack Leckie of Huntington as Alternate Delegates.

Doctor Flood To Head Credentials Committee

Doctor Flood will serve as Chairman of the Credentials Committee at this year's convention. The Credentials Committee is responsible for certifying the participation of voting delegates and for review of any questions regarding the credentials of individual members of the House.

Dr. Stephen D. Ward of Wheeling is a member of the AMA's Council on Legislation.

General sessions of the convention will deal with, "The Endorphin Story," "Coronary Bypass Surgery," "Effect of Moderate Drinking" and "'Newer Development in Computed Tomography Scanning."

Dr. Jack J. Stark, right, of Vienna was presented the 1978 "Mr. Doc" award for his contributions to the practice of medicine by the West Virginia Chapter, American Academy of Family Physicians during the chapter's annual scientific assembly held this spring in Charleston. Above, Dr. Asel P. Hatfield (left) of Harrisville, who was installed as President during the meeting, presents the award to Doctor Stark. Looking on is Dr. Carl B. Hall of Charleston, Past President of the national Academy, who presided during the ceremony.

The AMA specialty sections will present programs in 28 different medical specialties.

Special program topics will include, "Therapeutic Approaches to the Rape Victim," "Psychology-Biology Origins of Maleness and Femaleness," "Physicians' Marriages," and "Nutrition."

Medical motion picture showings will be held during the meeting. Some 100 scientific exhibits and 125 industrial exhibits will offer visual displays of new developments in medical care.

The AMA Auxiliary will hold its convention simultaneously with the AMA convention.

The 20th AMA National Conference on Medical Aspects of Sports will be held in St. Louis, June 17.

Hospital Applications Invited By Education Network

Applications are now being invited for membership in the Ohio Medical Education Network (O-M-E-N), which begins its seventeenth year of service in mid-September. OMEN describes itself as "the largest, accredited, two-way, visually augmented, amplified telephone network for physicians in North America." During this past season, medical staffs at 109 hospitals in seven states and Canada took part in these continuing medical education seminars. While the programs *originate* "live" from The Ohio State University campus in Columbus, the conferences are actually *held* at participating hospitals, many of which are located hundreds of miles away.

Each of the 30 once-a-week programs begins at 12:30 P.M. Eastern time, and lasts one hour. One hour of Category 1 credit is available for each program from the American Medical Association. Continuing education study credit is also provided by the American Academy of Family Physicians. The 1978-1979 season starts the week of September 19, 1978, and continues through the first week of May, 1979, with breaks during Thanksgiving week, Christmas week, and New Year's week.

Through the use of microphones and telephones, linked to amplifiers and loud speakers at participating hospitals, OMEN overcomes geographical barriers to promote exchanges of experiences and new ideas between practicing physicians in widely separated settings and leading medical educators at four medical schools. During the coming season, more than 60 academi-

cians will present the latest available information on a wide variety of topics. Faculty will be drawn from the medical schools at The Ohio State University in Columbus, the University of Cincinnati, Case Western Reserve in Cleveland, and the Medical College of Ohio at Toledo.

10 West Virginia Hospitals

Ten West Virginia hospitals participated in the network this past year. They were: Camden-Clark in Parkersburg, Wheeling in Wheeling, Man Appalachian Regional in Man, Jefferson Memorial in Ranson, Fairmont Clinic in Fairmont, Summers County in Hinton, Grafton City in Grafton, Pleasant Valley in Point Pleasant, and Veterans Administration and Huntington, Inc., in Huntington. Camden-Clark begins its 14th year with the network this season, while Wheeling Hospital begins its 16th year.

The basic cost of taking part in the series includes a sliding-scale, per-program OMEN administrative charge which is based on hospital bed size. This amounts to $23 per program for hospitals with 100 to 199 beds, $26 for those with 200 to 299 beds, and $29 for facilities with 300 or more beds. Participating hospitals are also responsible for covering the long distance expenses, as well as other charges from their local telephone companies.

Individuals wishing more complete information on the network are invited to call (614) 422-4986, or write: Arthur A. Bartfay, Networks and Media Coordinator, Center for Continuing Medical Education, The Ohio State University, A-354 Starling Loving Hall, Columbus, Ohio 43210.

Ophthalmologists Question FDA Regulations For Lenses

Editor's Note: The government's most recent effort to regulate medical devices is profiled in the study described here. The principle prompting the investigation, that of examining the safety of intraocular lenses (IOLs), is questioned by ophthalmologists who have used them safely.

This study, according to the West Virginia Academy of Ophthalmology and Otolaryngology, places a great burden of responsibility on the physician. He must maintain adequate records and adhere to a punctual reporting schedule. Unless he complies with these regulations his right to implant IOLs will be denied. Below is the West Virginia Academy's assessment of the study.

Ophthalmology has historically been a pacesetter in medicine: establishing the first board, the first and finest continuing education program and some of the most sought-after training programs.

The 26th annual Scientific Assembly of the West Virginia Chapter, American Academy of Family Physicians, met in April in Charleston. New officers elected for 1978-79 and others shown above are, front row, from left, Drs. Thomas P. Long, Man, President-Elect; Thomas L. Ritz, Wheeling, Secretary; Asel P. Hatfield, Harrisville, President; L. Dale Simmons, Clarksburg, Alternate Delegate to the AAFP, and Kenneth R. Chasteen, Huntington, Resident Member of the Board of Directors; back row, from left, Drs. Robert D. Hess, Clarksburg, Treasurer; John L. Fullmer, Morgantown, Vice President; Del Roy R. Davis, Kingwood, AAFP Delegate; Marshall J. Carper, Charleston, immediate Past President and Chairman of the Board; Jack J. Stark, Vienna, 1978 "Mr. Doc" award recipient, and Joseph A. Smith, Dunbar, AAFP Delegate.

Now, in what will become the largest investigation man has ever conducted, ophthalmology has again been cast in a leader's role. Even though a vast body of ophthalmologists knows that intraocular lenses (IOLs) are safe, the Food and Drug Administration has ordered a thorough investigation to prove the safety and efficacy of IOLs to their colleagues, the scientific community, and the public. This study was prompted by the FDA based on the Medical Device Amendment of 1976 and is the first medical "device" to be so studied.

The final regulations of the FDA were published in November, 1977. Ninety days after publication, in February, 1978, each ophthalmologist was to meet the standards of, and receive approval as an investigator by, one or more IOL manufacturers. Otherwise, he can no longer legally implant IOLs.

To qualify as an investigator, the ophthalmologist must submit a *curriculum vitae*, list of courses, hours spent both in study of IOLs and in practice labs, and his own experience with IOLs.

Committee Established

Additionally, the hospital in which he practices must establish an Institutional Review Committee (IRC). The committee should be composed of one or more non-scientists who could be selected from the fields of law, the clergy, sociology, ethics, hospital administration, and so forth. The investigator cannot be a voting member of the committee or help select its members.

The IRC reviews the protocol for the study and decides on its risk/benefit ratio. Some ophthalmologists have expressed concern that a procedure they have done safely for years has suddenly been termed "research" or "experimentation." However, the IRC's review should actually decrease the chance for legal action by the patient.

Before the FDA can approve an investigator, IRC approval is essential. Without it the sponsor cannot send lenses to the investigator. The IRC must keep records of protocol and untoward effects. At any time the FDA has the right to audit the records of the committee or the records of the physician involved. This type of research approval has been utilized in academic centers for years in new drug investigations.

The investigator (ophthalmologist) will participate either as a core or adjunct investigator in a part of one of two studies. In both, the information gathered and recorded on flow sheets will be the same. The surgeon sends the sponsor (lens manufacturer) the results of his preoperative evaluation, operative results, and postoperative visits. The material gathered in both investigations is similar, differing only in its duration. The core investigation records in detail any early and long-term problems associated with the lens and implantation, while the adjunct investigation has less recording obligation in compiling longe-range safety data.

Complications Studied

If any potentially serious complications are identified during the study, the FDA is notified and an in-depth study is initiated to determine the cause of the complication.

With consent form, the patient agrees to participate in the study and to return for follow-up visits for a year after surgery.

The manufacturers agree to abide by lens specifications established by the FDA. They must also maintain all records concerning their lenses in animal studies and preclinical trials, and detailed records on each lens implanted in their study. These records are open to FDA investigators.

The FDA reviews all relevant material submitted and compiled in this study and, after a three-year investigation, will issue a verdict upon the safety of IOLs.

WVU, MU Medical Schools Get AMA-ERF Grants

The West Virginia University and Marshall University medical schools have received $15,695.28 and $4,062.59, respectively, from the Education and Research Foundation of the American Medical Association. Formal recognition of the grants will be a part of the program for the first session of the House of Delegates of the 111th Annual Meeting of the State Medical Association to be held August 23-26 at the Greenbrier in White Sulphur Springs.

The AMA-ERF funds are provided annually by direct contributions from physicians and by the fund-raising efforts of medical society auxiliaries across the nation. Most of them are earmarked for specific medical schools, according to the wishes of the donors.

A total of $1,150,697 in individual grants was received by North American medical schools this spring, the AMA-ERF announced.

Tygart's Valley Postgraduate Session June 15

The 29th annual Postgraduate Session of the Tygart's Valley Medical Society will be held on June 15 at the Elks Country Club in Elkins.

The speakers and topics for this year's scientific program will include:

"Pelvic Cancer in Women: a Potpourri"—Watson G. Watring, M. D., Director, Division of

Watson G. Watring, M. D.

Alvin L. Watne, M. D.

Gynecological Oncology, New England Medical Center Hospital, Boston; "Cardiopulmonary Resuscitation Update"—Juan F. Gutierrez, M. D., Department of Anesthesia, West Virginia University Medical Center, Morgantown, and (as an Encore), "Air Pollution, Smoking and Health;"

"Diagnosis and Treatment of Diverticular Disease"—Alvin L. Watne, M. D., Professor and Chairman, Department of Surgery, WVU Medical Center, Morgantown, and "Diabetes in Pregnancy"— David J. S. Hunter, M. D., Department of Obstetrics and Gynecology, WVU Medical Center, Morgantown.

David J. S. Hunter, M. D.

A social hour and dinner program will follow the scentific program.

It is anticipated that the course will be approved for four hours of credit in Category 1 of the Physician's Recognition Award of the American Medical Association.

For additional information, contact Dr. Vernon E. Duckwall, Elkins (telephone 304-636-1243).

Review A Book

The following books have been received by the Headquarters Office of the State Medical Association. Medical readers interested in reviewing any of these volumes should address their requests to Editor, *The West Virginia Medical Journal*, Post Office Box 1031, Charleston 25324. We shall be happy to send the books to you, and you may keep them for your personal libraries after submitting to *The Journal* a review for publication. *Meanwhile, please see review of the book, "Occupational Diseases: A Syllabus of Signs and Systems," on page xxi.*—Editor.

Coal Workers' Pneumoconiosis—A Critical Review, by Aleksandra J. Kujawska, M. D.; Kazimierz J. Marek, M. D.; and Witold W. Zahorski, M. D. 108 pages. University Press of New England, Hanover, New Hampshire.

American Drug Index 1977, by Norman F. Billups, Ph. D., R. Ph. 735 pages. Price $14.50. J. B. Lippincott Company, Philadelphia, Toronto.

The Physician's Assistant: A Baccalaureate Curriculum, by Hu C. Myers, M. D. 153 pages. Price $6.18. Alderson-Broaddus College (McClain Press), Philippi, West Virginia 26416. 1977.

Genetic Screening: Programs, Principles, and Research, by the National Academy of Sciences (Committee for the Study of Inborn Errors of Metabolism, Division of Medical Sciences, Assembly of Life Sciences, National Research Council). 388 pages. 2101 Constitution Avenue, N.W., Washington, D. C. 20418. 1975.

Council Reviews Legislative, Health Plan Activities

The State Medical Association's Council reviewed 1977 legislative enactments, including a new generic drug substitution law to become effective July 1, among a variety of topics on the agenda for its Spring Meeting in Charleston April 23.

In other action, the Council:

—Was advised by Dr. Joseph A. Smith of Dunbar, the Association President, of his appointment of Dr. Arthur E. Levy of Williamson as Councilor from District XIV, embracing Wyoming, McDowell, Logan and Mingo counties, to succeed Dr. Ray M. Kessel, who resigned.

—Adopted a motion commending Doctor Kessel, who has moved from Logan to Huntington,

for his long years of service to the Medical Association.

—Elected to honorary membership, subject to confirmation by the House of Delegates in August, the following physicians who have been accorded similar status by component medical societies: Drs. H. W. Angell and N. H. Dyer, both of Charleston; O. M. Harper, Clendenin; Paul C. Soulsby and Silas C. Wiersma, both of St. Albans; Paul E. Walker of Crystal River, Florida, formerly of Mingo County; Paul L. McCuskey, Parkersburg, and Michael A. Viggiano of New Martinsville.

—Endorsed a voluntary West Virginia Emergency Facility Categorization Plan being implemented in the state through efforts of the State Health Department's Office of Emergency Medical Services and others, and developed through work by a joint Medical Association - West Virginia Hospital Association Committee.

—Approved an expenditure of up to $400, contingent upon actual need as determined by the Executive Committee, toward expenses of two West Virginia Medical Student Association representatives planning to attend the June 17-22 Annual Meeting of the American Medical Association in St. Louis.

Council discussed at considerable length continued development by the West Virginia Health Systems Agency, Inc., of a Health Systems Plan for the State; and steps taken by the Medical Association and others to assure more input into the ongoing planning process.

In a related matter, Dr. Robert K. Modlin of Ronceverte, Secretary of the Greenbrier Medical Society, outlined that component's concerns about procedures toward certification of new health care facilities, including a proposed rural clinic in the general Williamsburg area.

The Association's Executive Secretary, Mr. Charles R. Lewis, requested and obtained from Dr. George E. Pickett, West Virginia's State Health Director who participated in the Council session, assurances that communications between the Health Department and Association would be tightened to make certain Mr. Lewis' office is kept abreast of rural clinic and related applications for certificates of need which must be filed with the health agency.

Mr. Lewis said he, in turn, would make certain that component medical societies in areas where new facilities are proposed will be informed of such filings in order that they might offer any comments, at public hearings or otherwise, they might deem appropriate.

Mrs. Robert D. Hess Author Of Historical Work

Editor's Note: The upcoming new book, *History of Medicine in Harrison County, West Virginia*, is reviewed below by Dr. Robert S. Wilson of Clarksburg.

History of Medicine in Harrison County, West ginia, soon to be published by McClain Publishing Company in Parsons, West Virginia, is an exhaustive study of the art by Alice Jo Hess and edited by Sister Mary Ruth Owen.

Mrs. Hess, wife of [West Virginia State Medical Association] President-Elect Robert D. Hess, M. D., of Clarksburg, has spent seven years in preparation of her manuscript. She presents a brief history of medicine from the earliest times to the present and, more specifically, medicine as practiced by Harrison County physicians since 1791. Biographies of each and every practitioner since William Williams arrived in 1791 to our recent influx of physicians in 1976-77 are included. These biographies have much geneological value, and many colorful, interesting and amusing happenings are recorded by Mrs. Hess.

A description of, and fate of, the several hospitals that have been formed in Harrison County are presented.

The minutes of the Harrison County Medical Society have also been reviewed.

In preparation of this monumental work, Mrs. Hess has reviewed all available writing pertaining to Harrison County history and medicine. She has interviewed many relatives personally, has perused court records and has combed most of the local cemeteries in Harrison and surrounding counties.

Over two hundred photographs illustrate her work.

She is to be congratulated for a work well done.

Her book is dedicated to the late George F. Evans, M. D., of Clarksburg, Past President of the West Virginia State Medical Association and Editor of *The West Virginia Medical Journal*.—Robert S. Wilson, M. D.

Occupational Health Director

Jermyn F. McCahan, M. D., Medical Director of American Telephone and Telegraph Co. Long Lines, has been named Head of Occupational Health Activities for the American Medical Association.

AMA To Honor Arizona Doctor For Perinatal Care Work

Phoenix pediatrician H. Belton P. Meyer, M. D., is the recipient of the American Medical Association's first William Beaumont Award for outstanding contributions to medical research, teaching or clinical practice by a physician under age 50.

The award, formerly known as the Arnold and Marie Schwartz Award in Medicine, consists of a $2,500 stipend and plaque. It will be presented at the AMA Annual Meeting in St. Louis this month.

The AMA Board of Trustees voted to rename the award in honor of William Beaumont, M. D., the 19th century Army physician who advanced knowledge of digestive processes and gastroenterology, and who is buried in St. Louis.

Doctor Meyer, 43, has received national recognition for his leadership in Arizona perinatal care programs.

This began in 1967 when he was appointed Medical Director of the Arizona State Newborn Transport and Intensive Care Program. The program, which had been planned and organized by several Arizona health leaders over a period of years, was put into operation under Doctor Meyer's direction.

The program gained wide recognition for its concept of transporting rural-born, critically ill infants to regional care centers, and for its success in reducing death rates among these infants. In the past 10 years, Arizona has achieved one of the nation's best neonatal mortality rates.

Doctor Meyer is a member of the AMA Committee on Maternal and Child Care, the Fetus and Newborn Committee of the American Academy of Pediatrics, the Committee on Perinatal Mortality of the American College of Obstetrics and Gynecology, and the Subcommittee on Maternal and Infant Care of the American Public Health Association.

MEDICAL WRITING

Experienced medical writer with pharmacy degree will ghostwrite, rewrite, edit or proofread technical or general papers, articles, textbooks, handouts, educational materials etc. Local references available, fees mutually agreed before work commences. J. Marion Anderson, 90 School St., Morgantown WV 26505. Telephone 304-599-9319.

Medical Meetings

June 3—Fifth Annual Wildwater Surgical Conference, Charleston.

June 8-9—Visiting Professor, Dept. of Obstet. & Gynecol., WVU Medical Center, Morgantown.

June 10—W. Va. State Society of Anesthesiologists, Morgantown.

June 11-13—Am. Diabetes Assn., Boston.

June 11-15—Am. Society of Colon & Rectal Surgeons, San Diego.

June 15—29th Annual Postgraduate Session, Tygart's Valley Medical Society, Elkins.

June 17—Common Arrhythmias and Their Management, WVU Medical Center, Morgantown.

June 17-22—AMA Annual Meeting, St. Louis.

June 21-24—Art & Science of Sports Medicine (University of Va. & Committee on Sports Medicine, Medical Society of Va.), Charlottesville, Va.

July 21-25—Am. Assn. for Clinical Immunology & Allergy, Newport Beach, Calif.

Aug. 23-26—111th Annual Meeting, W. Va. State Medical Assn., White Sulphur Springs.

Sept. 10-14—Am. Academy of Ophthalmology & Otolaryngology (Otolaryngology Section), Las Vegas.

Sept. 17-21—Kentucky Med. Assn., Louisville.

Sept. 22-24—Am. Neurological Assn., Washington, D. C.

Sept. 24-30—Am. College of Gastroenterology, Denver.

Sept. 25-28—AAFP, San Francisco.

Sept. 29-30—AMA Medical Staff Leadership Seminar, New York City.

Sept. 29-30—ASIM, Orlando, Fla.

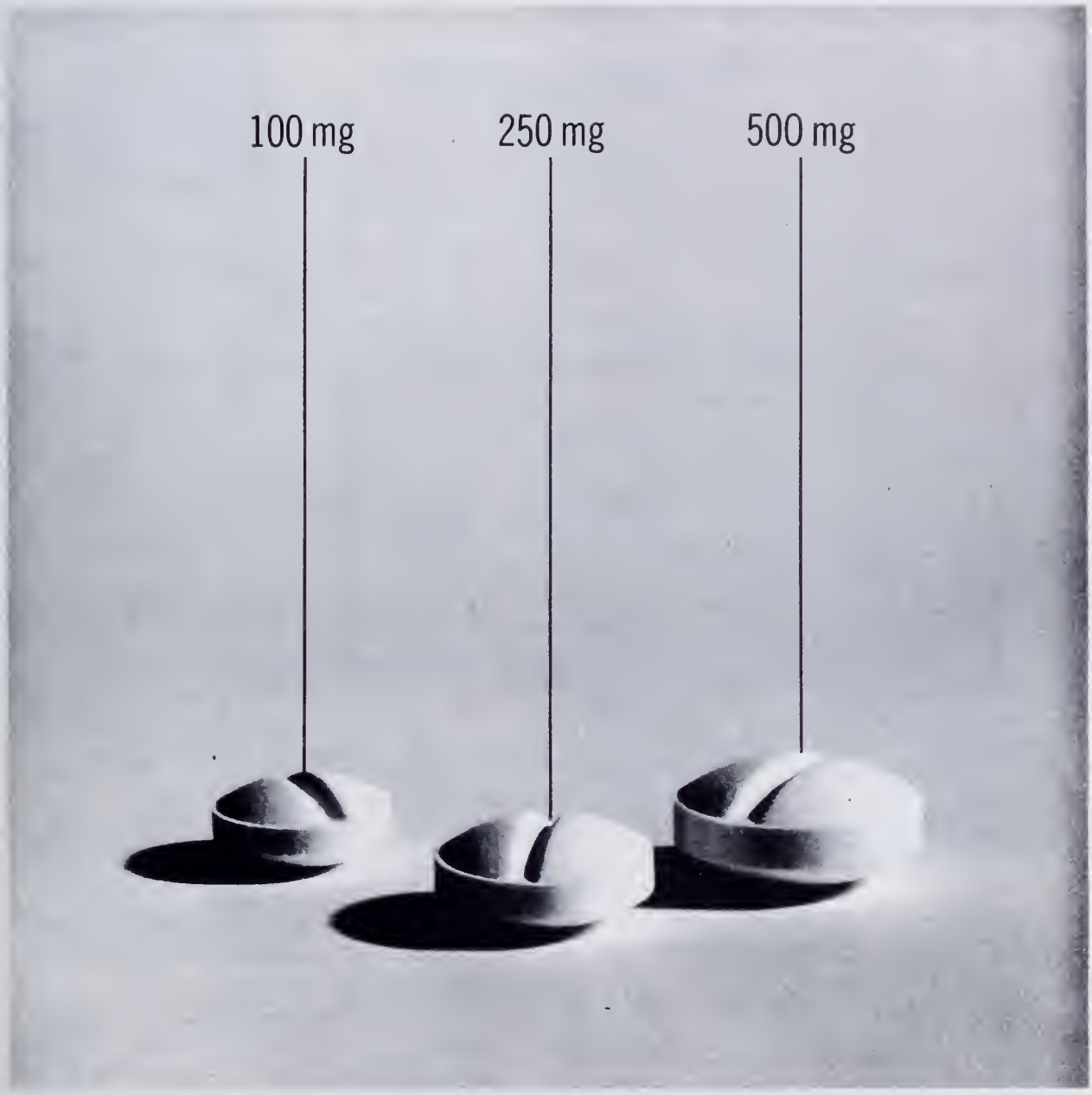
Oct. 25-29—Am. Academy of Child Psychiatry, San Diego.

Nov. 2-5—Med. Society of Virginia, Williamsburg.

Nov. 11-14—Southern Medical Assn., Atlanta.

1979

Jan. 26-28—12th Mid-Winter Clinical Conference, Charleston.



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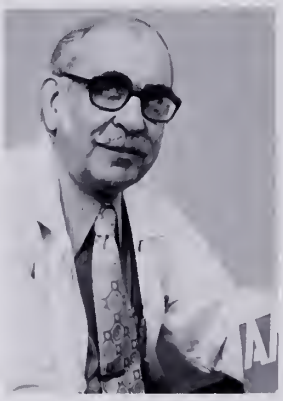
WVU Medical Center
–News–

Compiled from material furnished by Mrs. Mary Ellin Wylie, Director, Medical Center News and Information Services, Morgantown, W. Va.

Dr. Clark K. Sleeth Speaker For Honor Society

"A Historical Review of Medical Education in West Virginia" was Dr. Clark K. Sleeth's topic for the annual Alpha Omega Alpha Lecture held recently at the Medical Center prior to graduation exercises.



Clark K. Sleeth, M. D.

Former Dean of the School of Medicine (1961-1970) and now Professor of Medicine and Family Practice, Doctor Sleeth was invited this year by fellow members of the honor medical society's WVU chapter to present the group's annual address by a distinguished speaker. He will retire June 30 after a career on the University faculty spanning more than 40 years.

Doctor Sleeth became the second person, succeeding Dr. Edward J. Van Liere, to head the School of Medicine's four-year program, which began in 1958. He was serving when the first class was graduated in 1962, and presided over the continued orderly growth of the school. In 1970, after nine years as Dean, he requested and received release from his administrative duties so that he could return to his favorite activity—teaching medical students.

New members of AOA, including two from the faculty and seven each from the senior and junior classes, were introduced before the lecture. A dinner honoring them was held afterward at This Ole Farm.

Elected from the faculty were Dr. Stephen R. Amato, Associate Professor of Pediatrics, and Dr. Anthony DiBartolomeo, Assistant Professor of Medicine and Chairman of Rheumatology.

Seniors named were Richard Ball and Charles Singer of Wheeling, Robert Boyd of Talcott, Edward Gallagher, Shepherdstown; Thomas Howard, Mt. Hope; Frank Schwartz, Parkersburg, and Patricia Zekan, Charleston.

Juniors elected were Stephen Bower of Dunbar, Martha Hales and Samuel Mahaffey, Morgantown; Michael McIntosh, Parkersburg; Konrad Nau, Wheeling; Stephen Perkins, South Charleston, and Claude K. Shannon, Tunnelton.

Joseph M. Neal, a senior (now graduated) of Huntington, was President of AOA at WVU.

Virginia Anesthesiologist Joins Faculty

Dr. Terring W. Heironimus III has joined the faculty as Professor and Director of Respiratory Therapy in the Department of Anesthesiology.

Doctor Heironimus received his bachelor's degree from WVU and his medical degree from the University of Virginia.

Following his internship at the University of Pittsburgh, he spent two years in the Army Medical Corps before returning to the University of Virginia for his residency. He became a member of the faculty there in 1961 and most recently was Professor of Anesthesiology and Medical Director of Respiratory Therapy.

He also served as Director of the Respiratory Therapy Training Program at Piedmont Virginia Community College of Charlottesville and as a consultant anesthesiologist to the Naval Regional Medical Center in Portsmouth, Virginia.

Doctor Heironimus is the author or co-author of 16 publications detailing his research primarily in the areas of intensive care and respiratory therapy.

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Third-Party News, Views and Program Concerns

Research Achievements, Needs Described In Report

The National Heart, Lung, and Blood Institute has announced the availability of the "Fifth Report of the National Heart, Lung, and Blood Advisory Council." The Council, composed of leading members of the scientific community and lay public, is the Institute's primary advisory group.

The report describes achievements and needs of biomedical research programs supported by the Institute, which celebrates its 30th anniversary this year.

One of the major trends highlighted by the report is the declining death rate from cardiovascular diseases. The decline began 25 years ago and has accelerated in recent years. The total decrease from 1950 is 30 per cent, a significant slowdown in the mortality rate for what has been for years, and still is, by far the number one cause of death in this country.

It is reasonable to conclude, to quote the report, that "the last three decades of research and public education into the causes and prevention of heart attack and stroke, supported in significant part by the National Heart, Lung, and Blood Institute, are responsible for this decline in mortality."

Single copies of the report are available from the Publications Section, Office of Information, National Heart, Lung, and Blood Institute, Bethesda, Maryland 20014.

Medical Practice, Technology Evaluation Bills Opposed

Two bills to centralize the evaluation of the use and cost effectiveness of medical technology and practice were opposed by the American Medical Association recently in testimony before the House Commerce Subcommittee on Health. William C. Felch, M. D., Chairman of the Council on Legislation, said the bills (HR 4869 and HR 10839) "not only could lead to a stifling of research and other creative initiatives that are necessary to improve the quality of medical services available to patients in the future, but also could serve to regiment and limit physician options in providing treatment to patients on an individualized basis."

HR 4869 would establish a Center for the Evaluation of Medical Practice within the National Institutes of Health. HR 10839 would create a National Center for Evaluation of Medical Technology.

Cost effectiveness is a legitimate concern, Doctor Felch said, "but it cannot be allowed to overshadow the true purposes of medical treatment and technological development—the saving of lives, the alleviation of pain and suffering, and the rehabilitation of those who are ill." The bills would duplicate efforts to set guidelines under the PSRO and health planning laws and would not take local circumstances into consideration, he said.

PSRO Records Public Documents, Federal Judge Rules

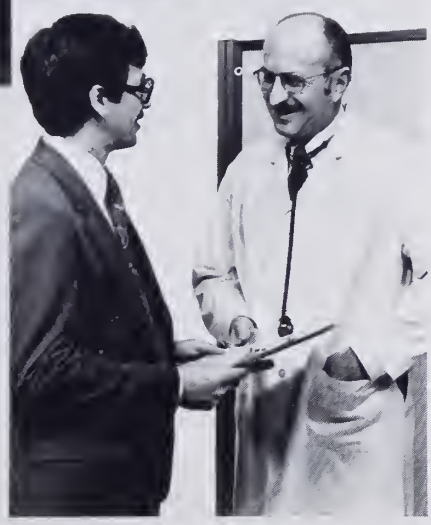
Records kept by PSROs are public documents that may be obtained under the Freedom of Information Act, a federal judge in Washington, D. C., ruled recently. In a lawsuit brought against a Washington PSRO by Ralph Nader's Public Citizen Health Research Group, which sued to obtain the PSRO's records, U. S. District Judge Gerhard Gesell maintained that the crucial role played by the PSRO in the public health process makes it a public agency subject to disclosure of public records.

The PSRO argued that it acts as a consulant to HEW.

The Nader group sought all of the PSRO's records except those involving identifiable names of patients. Records involving the individual physician-patient relationship are exempt from disclosure under the Freedom of Information Act.

A lawyer for the PSRO, National Capital Medical Foundation, Inc., said he is confident the decision will be appealed.

Working together is the best medicine.



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Obituaries

DAVID E. WALLACE, M. D.

Dr. David E. Wallace of Madison, Boone County Health Director and former member of the State Senate, was found dead on April 24 at Boone Memorial Hospital there. He was 42.

Doctor Wallace had been on duty in the hospital's emergency room shortly before he was found dead in the x-ray department.

Doctor Wallace served in the State Senate in 1971, 1972 and part of 1973, when he resigned. He represented the Seventh Senatorial District comprised of Boone, Logan and Lincoln counties.

He was graduated from Morris Harvey College and received his M. D. degree in 1963 from West Virginia University School of Medicine. He interned at Charleston Memorial Hospital.

Doctor Wallace was a member of the Boone County Medical Society, having served as Secretary and President (1971-72). He also was a member of the West Virginia State Medical Association.

Survivors include the widow; three sons, David, Richard and James Wallace, all at home; a brother, James Wallace of Van; a sister, Mrs. Alma Triplett of Charleston, and mother, Mrs. Bonnie Brooks of Van.

* * *

OSCAR D. BALLARD, M. D.

Dr. Oscar D. Ballard of High Point, North Carolina, who formerly practiced in Boone and Fayette counties, died on April 15 in a High Point Hospital. He was 68.

Doctor Ballard, a former member of the West Virginia State Medical Association, was graduated from West Virginia University and received his M. D. degree in 1938 from the University of Arkansas.

Doctor Ballard also had practiced in Los Angeles, and formerly was Director of the Student Health Center at the University of Southern California.

Survivors include the widow; a daughter, Lois K. VanHorn of Mount Hope; two brothers, Dr. William R. Ballard, Jr., of Los Angeles and Lewis W. Ballard of Fayetteville; and four sisters, Mrs. Sara Blanche Arritt and Mrs. Hope Caldwell, both of Fayetteville; Mrs. Katharine Anderson of Bristol, Tennessee, and Mrs. Elizabeth Stone of St. Albans.

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County Societies

McDOWELL

The McDowell County Medical Society met on April 12 in Welch at the Stevens Clinic Hospital.

The speaker was Charles W. Caldwell of Charleston, Deputy Director of the West Virginia Health Systems Agency, Inc. An interesting and extensive discussion followed Mr. Caldwell's presentation on the role of the HSA.—Muthusami Kuppusami, M. D., Secretary.

• • •

MONONGALIA

The Monongalia County Medical Society met on April 4 at the Old Mill Club in Morgantown.

The speaker for the scientific program was Dr. Stephen R. Amato from the West Virginia University Medical Center. His topic was "Genetic Evaluation and Counseling Center, West Virginia University."

Dr. Margaret I. Stemple gave the report of the ad hoc committee regarding the policy of the Society on medical investigation surveys and studies. The Society passed unanimously a motion by the committee that the Society should give approval only for investigations or scientific studies that have a clear and definite purpose with reasonable expectation of beneficial results directly to the local community or indirectly within the national scope of health care—and without causing any harm or unreasonable effects to the participants in the study.—Barbara Jones, M. D., Secretary.

• • •

CABELL

The Cabell County Medical Society met on March 9.

The speaker was Mr. Donald Frey of Charleston, Associate Director for Field Operations, West Virginia Health Systems Agency, Inc. Mr. Frey provided a historical review of HSA programs, with specific attention to the agency's activities in West Virginia. A question-and-answer period followed.—James R. Cook, M. D., Secretary.

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Annual Audit, 1977

The annual audit of receipts and disbursements of the West Virginia State Medical Association for the calendar year 1977 has been completed by the firm of Ernst & Ernst, Certified Public Accountants of Charleston. The completed audit, with accountants' report, follows:

ERNST & ERNST
716 Charleston National Plaza

To the Council
West Virginia State Medical Association
Charleston, West Virginia

We have examined the statements of assets, liabilities, and fund balances arising from cash transactions of the several funds of the West Virginia State Medical Association as of December 31, 1977 and 1976, and the related statements of revenues collected and expenses paid of the unrestricted funds and changes in fund balances of the several funds for the years then ended. Our examinations were made in accordance with generally accepted auditing standards and, accordingly, included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

As described in Note A, the Association's policy is to prepare its financial statements on the basis of cash receipts and disbursements; consequently, certain revenues and the related assets are recognized when received rather than when earned, and certain expenses are recognized when paid rather than when the obligation is incurred. Accordingly, the accompanying financial statements are not intended to present financial position and results of operations in conformity with generally accepted accounting principles.

In our opinion, the aforementioned financial statements present fairly the assets, liabilities, and fund balances arising from cash transactions of the several funds of the West Virginia State Medical Association at December 31, 1977 and 1976, and the revenues collected and expenses paid of the unrestricted funds and changes in fund balances of the several funds for the years then ended, on the basis of accounting described in Note A, which basis has been consistently applied.

ERNST & ERNST

Charleston, West Virginia
April 12, 1978

STATEMENTS OF ASSETS, LIABILITIES AND FUND BALANCES ARISING FROM CASH TRANSACTIONS
WEST VIRGINIA STATE MEDICAL ASSOCIATION

	December 31	
	1977	1976
UNRESTRICTED FUNDS		
ASSETS		
Cash	$160,427	$111,659
Certificates of deposit	78,212	78,212
Other assets	36	36
	$238,675	$189,907
LIABILITIES		
Payroll withholdings	$ —0—	$ 1,093
Due to restricted funds	8,387	8,024
FUND BALANCES		
Operations	217,892	168,434
Designated for professional liability education	12,396	12,356
	230,288	180,790
	$238,675	$189,907
RESTRICTED FUNDS		
ASSETS		
Cash	$ 37,291	$ 35,383
Certificates of deposit	7,805	7,805
Due from unrestricted funds	8,387	8,024
Investment in common stock	4,250	4,250
	$ 57,733	$ 55,462
FUND BALANCES		
Medical scholarship	$ 53,483	$ 51,212
Endowment	4,250	4,250
	$ 57,733	$ 55,462

See notes to financial statements

STATEMENTS OF REVENUES COLLECTED AND EXPENSES PAID—UNRESTRICTED FUNDS

Year Ended December 31

	1977	1976
REVENUES COLLECTED:		
Dues	$555,273	$530,120
Special assessment for professional liability education	40	6,170
Advertising	19,165	16,744
Interest	12,903	9,926
Contributions	3,925	4,998
Refund of expenses	1,452	1,899
Other revenues, including grants from endowment fund: 1977—$500; 1976—$448	10,852	9,473
	603,610	579,330
EXPENSES PAID:		
Dues remitted to AMA	305,285	292,250
Salaries and wages	79,034	77,043
Employee benefits	7,485	7,579
Taxes—payroll and other	3,698	3,678
Office rent	7,962	7,962
Office supplies and expenses	6,666	8,852
Telephone	3,771	4,683
Postage	7,840	8,381
Travel	27,544	24,323
Convention speakers and supplies	25,505	22,740
Publishing and printing	54,418	44,894
Other expenses	24,904	11,440
	554,112	513,825
EXCESS OF REVENUES COLLECTED OVER EXPENSES PAID	$ 49,498	$ 65,505

See notes to financial statements

STATEMENTS OF CHANGES IN FUND BALANCES ARISING FROM CASH TRANSACTIONS

Year Ended December 31, 1977 and 1976

		RESTRICTED FUNDS	
	Unrestricted Funds	Medical Scholarship Fund	Endowment Fund
Balance, December 31, 1975	$115,285	$ 50,448	$ 4,250
Excess of revenues collected over expenses paid	65,505		
Dues		9,930	
Repayment of scholarships		2,000	
Interest collected		1,809	
Contributions		25	
Scholarships to medical students		(13,000)	
Dividends received			448
Grant to unrestricted funds			(448)
Balance, December 31, 1976	$180,790	51,212	4,250
Excess of revenues collected over expenses paid	49,498		
Dues		21,663	
Repayment of scholarships		1,000	
Interest collected		1,908	
Contributions		700	
Scholarships to medical students		(23,000)	
Dividends received			500
Grant to unrestricted funds			(500)
Balance, December 31, 1977	$230,288	$ 53,483	$ 4,250

See notes to financial statements

NOTES TO FINANCIAL STATEMENTS
WEST VIRGINIA STATE MEDICAL ASSOCIATION

NOTE A — PRESENTATION OF FINANCIAL STATEMENTS

The financial statements are presented using the cash basis of accounting. Therefore, certain revenues and the related assets are recognized when received rather than when earned, and certain expenses are recognized when paid rather than when the obligation is incurred. Office equipment and other capital expenditures are charged to expense at time of purchase.

The Association has designated a special assessment to be used for professional liability education. The funds are to be used to inform physicians about current and potential problems with malpractice insurance and are accounted for as unrestricted funds.

Investments received as a gift or bequest are stated at fair market value as of date of grant.

The Association provides scholarships to students attending the School of Medicine of West Virginia University for the purpose of defraying expenses incurred by students. Under certain conditions, as set forth in the scholarship agreements, the scholarships are repayable to the Association in whole or in part. Scholarships to students and repayments are recorded as decreases and increases, respectively, in the medical scholarship fund balance.

NOTE B — LITIGATION

The Association is one of the defendants in a suit by a group of practitioners of Chiropractic Medicine against Blue Shield of Southern West Virginia and others. The suit alleges a violation of certain sections of the Sherman Act. Earlier dismissal in the lower courts was appealed by the plaintiffs and the action is to be scheduled for retrial.

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Book Review

OCCUPATIONAL DISEASES: A SYLLABUS OF SIGNS AND SYMPTOMS—E. R. Plunkett, M. D. The Barrett Book Company, 388 Summer Street, Stamford, Connecticut 06901. 352 Pages. 1977. Price $22.95.

This is a most unsatisfactory book. It is a series of entries with a symptom or a sign at the head, and a group of names of conditions, infections and toxins (potentially occupational) that could be the cause. The group is not necessarily very complete; for example, the heading, "Constipation," is followed by CNS trauma, strangulated hernia, actinomycosis, anthrax, brucellosis, leptospirosis, ornithosis, arsenic, fluorides, lead, nitrous fumes, tellurium, thallium and vanadium.

It is as though a tourist guide listed the names of streets according to the presence of individual types of shops (Shoes: Maple, Elm, High; Tobacco: Maple, Elm, Walnut, Pennsylvania Avenue, Broadway, etc.). Or a shopper's guide to chocolates listing the flavors (Hershey: milk, fruit and nut, peanut, etc.).

It seems unlikely that many practicing physicians would find this book useful.—R. John C. Pearson, M. D.

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The West Virginia Medical Journal

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MEMBER, WEST VIRGINIA PRESS ASSOCIATION, 1978

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The West Virginia Medical Journal

Vol. 74, No. 7 July, 1978

Review Article

A Diagnostic Approach To Anemia

JOHN S. ROGERS II, M. D.
Assistant Professor of Medicine, Division of Hematology, West Virginia University Medical Center, Morgantown.

A careful history and physical combined with a review of the peripheral smear and red blood cell indices and reticulocyte count should allow the clinician to narrow his diagnostic possibilities. Confirmation of the etiology of the anemia may then be obtained in the majority of cases with a few further laboratory studies.

The evaluation of anemia is a common diagnostic problem. A thorough history and physical along with a review of the peripheral smear and a few basic laboratory studies should allow the clinician to define the diagnosis in the majority of cases. An important point to remember is that a depressed hemoglobin is a symptom of underlying disease, the diagnosis and therapy of which is often of more significance to the patient than the anemia.

Anemia may be defined in reference to an abnormally low hemoglobin concentration. A value below 14 gms. per cent in the adult male and 12.5 gms. per cent in the adult female is generally considered subnormal. However, the recognition of mild anemia is inexact when based solely on the hemoglobin concentration. One adult male may be physiologically normal with a hemoglobin of 13.8 gms. per cent, while another may be anemic with a hemoglobin of 14.2 gms. per cent, having previously been noted to have a hemoglobin of 16.0 gms. per cent.

In the work-up of the anemic patient one must carefully consider a wide range of etiologic conditions. Blood loss, both acute and chronic, heads the list and accounts for approximately 50 per cent of cases. Chronic inflammation causes perhaps another 25 per cent. This broad category includes such conditions as rheumatoid arthritis, chronic infection, malignancy, chronic liver disease, hypothyroidism and collagen vascular disease. Red cell maturation abnormalities, such as B_{12} and folate deficiency, hemolytic anemias, decreased erythropoietin levels such as found in uremia, and marrow damage complete the list.

Historical Data

A detailed history is of major diagnostic importance. The clinician should try to document the onset of the anemia. Significant cerebral and circulatory symptoms suggest an acute onset and acquired disease. Persistent or recurrent anemia, along with a positive family history points to a congenital etiology. One should search carefully for a history of blood loss paying particular attention to the gastrointestinal tract and to the menstrual history in the female.

The patient should be specifically asked about episodes of jaundice or dark-colored urine. A complete list of medications and possible toxin exposure should be obtained. If a patient has received therapy for anemia in the past, knowledge of the response may be helpful. A dietary history should be obtained, particularly in regards to possible folic acid deficiency. Except in children under the age of two, whose diet may be limited to milk products, iron deficiency in the United States is due to blood loss, not dietary lack.

Again, history suggesting underlying disease should be carefully sought.

Physical Findings

A physical examination may be helpful in demonstrating the anemia. The patient may show pallor of the skin, mucous membranes or nail beds. A forceful cardiac impulse, tachycardia, hemic murmurs, or cardiac dilatation may be present.

Clues to the underlying etiology may be found. Examination of the skin and sclerae may demonstrate jaundice associated with hemolysis or liver disease. Petechiae suggest thrombocytopenia. Retinal hemorrhages may be seen with severe anemia or thrombocytopenia. Fundoscopic examination may also demonstrate the venous dilation seen with the hyperviscosity state of Waldenstrom's macroglobulinemia.

Inspection of the mouth may show the smooth tongue of pernicious anemia or severe iron deficiency. Mucosal ulceration or gum hypertrophy may be seen at times with acute leukemia. Abdominal examination may demonstrate the markedly enlarged spleen associated in the adult with chronic myelogenous leukemia, primary myelofibrosis, or malignant lymphoma. Enlargement of the liver suggests the possibility of acute or chronic liver disease or metastatic involvement.

Adenopathy, depending on its location and quality, might suggest infection, malignancy, systemic lupus erythematosus, or sarcoidosis. Decreased position and vibratory sensation are found in pernicious anemia. Hypoactive deep tendon reflexes suggest hypothyroidism.

Laboratory Studies

A careful history and physical should raise one or several diagnostic possibilities. Measurement of the hemoglobin and/or hematocrit will quantitate the presence and severity of the anemic state. The peripheral smear should then be examined and the red blood cell indices and reticulocyte count obtained.

The size and the hemoglobin content of the red blood cells allow one to classify an anemia into one of the three groups: hypochromic/microcytic, normochromic/normocytic, or macrocytic (Table 1). The peripheral smear may demonstrate other diagnostic clues. Polychromatophilic macrocytes and nucleated red blood cells suggest early release of developing red blood cells due either to hemolysis or acute blood loss. Spherocytosis suggests the diagnosis of hereditary spherocytosis or autoimmune hemolytic anemia. Fragmented red blood cells may be seen with prosthetic heart valves or microangiopathic states such as thrombotic thrombocytopenic purpura or malignant hypertension.

TABLE 1

A. Hypochromic, Microcytic Anemia
   1. Iron Deficiency
   2. Thalassemia
   3. Sideroblastic Anemia
   4. Lead Poisoning

B. Normochromic, Normocytic Anemia
   1. Chronic Inflammatory States
   2. Malignancies
   3. Chronic Renal Disease
   4. Hypothyroidism
   5. Marrow Suppression — Drugs or Toxins
   6. Leukemia
   7. Myelofibrosis
   8. Myelophthisic Anemia
   9. Refractory Normoblastic Anemia
   10. Hemolytic Anemias

C. Macrocytic Anemia
   1. Megaloblastic Anemia
   2. Chronic Liver Disease
   3. Hemolytic Anemia (with marked reticulocytosis)

Sickle forms are seen with sickle cell anemia. Agglutinated cells are produced by high titers of red cell cold agglutinin antibodies. Tear-drop forms and nucleated red blood cells are found in myelofibrosis and myelophthisic anemia. Target cells may be seen in thalassemic syndromes, several of the hemoglobinopathies and liver disease. The oval macrocyte is a characteristic of megaloblastic anemia, as are hypersegmented neutrophils.

Immature white blood cells may suggest leukemia, a leukamoid reaction or myelofibrosis. Likewise, abnormalities of the platelet count can be seen in anemias associated with leukemia, myeloproliferative disorders, malignancies, drug and toxin exposure, acute blood loss, or iron deficiency. Rouleaux formation may be found with plasma paraproteins associated with myeloma and Waldenstrom's macroglobulinemia.

The reticulocyte count is useful in separating hemolytic anemia from those caused by a red cell hypoproliferative state or maturation abnormality (Table 2). The reticulocyte count should be corrected for the degree of depression in the patient's red blood cell count:

(A) A corrected reticulocyte count of greater than three per cent is consistent with hemolysis, acute blood loss, or the recent administration of a deficient hematinic, e.g., iron therapy given for iron-deficiency anemia. Further evidence for hemolysis would include an increase in serum indirect bilirubin and LDH and a decrease in the serum haptoglobin. The bone marrow would show erythroid hyperplasia.

TABLE 2

A. Hypoproliferative State
   1. Iron Deficiency
   2. Chronic Inflammation
   3. Renal Disease
   4. Toxin Exposure
   5. Myelophthisic Anemias
   6. Intrinsic Marrow Disease

B. Maturation Abnormalities
   1. B_{12} Deficiency
   2. Folate Deficiency
   3. Myelofibrosis
   4. Sideroblastic Anemia
   5. Intrinsic Marrow Disease

C. Hemolytic Anemia
   1. Abnormal Hemoglobins
   2. Abnormal Red Cell Metabolism
   3. Membrane Abnormalities
   4. Immune-Isohemagglutinins, Auto-Antibodies, Drug-Related Antibodies
   5. Mechanical Damage – TTP, Prosthetic Heart Valves
   6. Alterations in Plasma Lipids
   7. Infectious Agents and Toxins

(B) The reticulocyte count is less than two per cent in the patient with red cell maturation abnormalities. The bone marrow aspirate will demonstrate erythroid hyperplasia. Megaloblastic changes may be present. The serum indirect bilirubin and LDH are often increased due to premature destruction of the abnormal red blood cells in the marrow.

(C) The hypoproliferative red cell state will have a corrected reticulocyte count of less than two per cent. The marrow will not show erythroid hyperplasia and the morphology will be normal. The serum indirect bilirubin and LDH will also be normal.

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And Now For A Quiz On The Material Presented Above!

(Answers on Page xiv)

For each of the questions, please choose one of the following responses:

1. a, b, c
2. a, c
3. b, d
4. d
5. all of the above

1. A patient with pernicious anemia might be expected to have:
   a. megaloblastic bone marrow
   b. corrected reticulocyte count greater than three per cent
   c. elevated serum indirect bilirubin
   d. hypochromic, microcytic red cell indices

2. The corrected reticulocyte count is elevated in:
   a. iron deficiency
   b. hemolysis
   c. megaloblastic anemia
   d. acute blood loss

3. Myelophthistic anemia is characterized by:
   a. tear-drop forms and nucleated red cells in the peripheral smear
   b. absent marrow iron stores
   c. metastatic tumor involving the bone marrow
   d. elevated reticulocyte count

4. A patient presents with anemia associated with jaundice, an elevated reticulocyte count, and a peripheral smear demonstrating spherocytosis. The following information should aid in establishing the diagnosis:
   a. family history
   b. serum iron
   c. direct Coomb's test
   d. serum folate

5. In an adult patient with proven iron-deficiency anemia it is important to:
   a. encourage proper dietary habits
   b. take careful dietary history
   c. look for coexistent folate deficiency
   d. search for a source of blood loss

6. Anemia associated with hypothyroidism typically demonstrates:
   a. normal marrow morphology
   b. normal serum indirect bilirubin
   c. normochromic/normocytic red cell indices
   d. corrected reticulocyte count greater than three per cent

7. Early marrow release of developing red blood cells is suggested by:
   a. increased number of polychromatophilic macrocytes on the peripheral smear

b. increased numbers of nucleated red blood cells on the peripheral smear

c. corrected reticulocyte count greater than three per cent

d. corrected reticulocyte count less than two per cent

8. An adult female with a hemoglobin of 12.2 gms. per cent:

a. may be physiologically normal

b. may be anemic

c. should have a careful history and physical with further work-up as clinically indicated if a repeated hemoglobin is again less than 12.5 gms. per cent.

d. should have an extensive work-up for her anemia

9. An abnormal dietary history is associated with anemia due to:

a. B_{12} deficiency

b. iron deficiency

c. pyridoxine responsive sideroblastic anemia

d. folate deficiency

10. Blood loss may be either acute or chronic and be associated with an anemia characterized by:

a. normochromic/normocytic red cell indices

b. hypochromic/microcytic red cell indices

c. a corrected reticulocyte count greater than three per cent

d. a corrected reticulocyte count less than two per cent

Manuscript Information

Manuscripts to be presented for publication in *The West Virginia Medical Journal* should be typewritten, triple-spaced, on one side only of firm (no onion skin or flimsy), standard letter sized (8 1/2 by 11 in.) white paper. Wide margins (at least 1 1/4 in. on left) should be left free of typing. On the first or title page should be shown the title of the article, the name (or names) of the author, and his degrees. Pages should be numbered consecutively, the page number being shown in the right upper corner along with the surname of the author.

Where reference is made to generically-designated drugs, the first such reference must be followed by parentheses containing the most commonly known trade-name drug of that designation. In addition, a listing of all generic drugs mentioned in the article, with their trade-name equivalents, should appear at the end of the article.

A short abstract summarizing the manuscript should be included. This should be typed in double space on a separate page.

Authors are requested to submit a carbon copy with the original.

Illustrations should be numbered and their approximate locations shown in the text. Each should be identified by placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for reproduction should be done in black (India) ink on pure white. Photographs should be on glossy paper and minimum of about 5 by 7 in. in size. A legend should be provided for each illustration and, preferably, attached to it.

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Facial Trauma: Initial Evaluation And Management

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The purpose of this discussion is to illustrate some of the principles of early management in facial trauma which may be useful to those physicians who see major facial trauma relatively infrequently, perhaps while in the course of providing emergency room coverage.

FACIAL trauma deserves special attention, for an understanding of the principles involved in initial management can prevent irreparable damage to function as well as appearance. Because of the broad implications in the management of a multiple-trauma victim who may also have pre-existing medical problems, it is important that an experienced physician have overall responsibility for the patient's care.[1]

Initial General Evaluation

Sympathetic reaction to grotesque facial trauma can result in distraction and diminished efficiency in the emergency room. The goals and priorities in treating such patients must therefore be kept in mind. The two major life-threatening hazards to a patient with major facial trauma are airway obstruction and hemorrhage.

Assuring a good airway is the first priority in managing any kind of trauma patient and is especially true in facial trauma. An airway is presumed to be obstructed if no air can be heard or felt moving in and out of the victim's mouth or nose; however, attempted respiratory movements of chest and abdomen may be apparent. The oropharynx must be cleared quickly of blood, vomitus, fractured teeth or broken dentures by scooping such materials out digitally in combination with a suction apparatus. A comminuted mandibular fracture in a supine patient may permit oral soft tissues to fall posteriorly, causing airway obstruction. This obstruction can be relieved by forward traction on the mandible. In the absence of spinal injury or other significant injuries, the lateral decubitus position is the safest and most comfortable position for the patient. Gravity thus aids in keeping the oropharynx clear of secretions and unsupported soft tissues.

Brisk hemorrhage from facial lacerations can be quite alarming but usually can be controlled with direct digital pressure or with compressive dressings. Attempts at blind clamping of bleeding vessels should be avoided since additional damage to structures such as the facial nerve may result. Unremitting oral and nasal hemorrhage secondary to facial fractures may require packing or, in extreme cases, ligation of the external carotid arteries.

Soft-Tissue Injury

Careful physical examination and inventory of the facial wounds provide the necessary information for accurate diagnosis.

Injury to any of the branches of the facial nerve should be suspected if a laceration involves the lateral aspect of face. Diagnosis can be established by observing facial muscle activity as the patient attempts to whistle, say "E", wrinkle his nose, close his eyelids tightly or wrinkle his forehead in an extreme upward gaze. A nerve stimulator may be used in special circumstances such as in an unconscious or anesthetized patient. Such testing must be performed prior to infiltration of the wounds with a local anesthetic agent which necessarily paralyzes the adjacent muscles. If injury to the parotid duct is suspected, confirmation can be obtained by passing a probe retrograde through Stensen's duct.

Suspected injury to the ocular globe should be evaluated by an ophthalmologist. Such an examination may also reveal previously undiagnosed ocular disease and thereby preclude misunderstandings about the role of a recent trauma in a convalescing patient's visual difficulties.

Skeletal Injury

Gross skeletal injury can usually be diagnosed by careful observation and palpation. Radiographs are a useful adjunct. Since the quality of films is usually disappointing if they are obtained in an agitated or uncooperative patient or during off-hours, more meaningful information will be available by postponing the studies until more ideal circumstances exist.

Epistaxis, swelling and tenderness in association with gross deviation are common findings in nasal fractures. Many unnecessary radiographs are obtained in order to confirm the obvious.

Isolated fracture of the zygoma is usually the result of a blow with a fist or other blunt object and gives the appearance of flattening of the malar eminence. Initial edema may mask temporarily the extent of the deformity. Other phys-

ical findings may include a palpable "step-off" on the infraorbital rim and hypesthesia in the upper lip, tip of nose and cheek. Significant associated fracture of the contiguous orbital floor may cause entrapment of extraocular muscles or other periorbital tissues; this is manifested by diplopia and limitation of motion of the affected globe.

Fractures of the middle third of the face (predominantly maxilla) may be just above and parallel to the palate (Le Fort I), may include the nasal pyramid plus maxilla (Le Fort II) or may totally disjoin the facial skeleton from the cranium (Le Fort III). All three types of fracture have in common mobility of the upper alveolar arch which can be tested for by grasping and moving the upper anterior teeth.

Mandibular fractures are frequently multiple and usually have associated gingival lacerations if the anterior arch is involved. There may be asymmetry of mandibular contour, limitation of mandibular excursion and dental malocclusion. Since small aberrations of interdental occlusal relationships are readily appreciated by the patient, he can be asked to bite his "back teeth" in order to demonstrate the existence of a malocclusion.

Role of X-Ray

X-ray studies play a definite, but not exclusive role in evaluating the extent of facial skeletal injury and in confirming a clinical diagnosis.

Gross fractures of facial bones are detectable by physical examination, in which case x-rays are not necessary in making the diagnosis. In other instances, significant fractures may not be visualized by x-ray as a result of patient-positioning and the presence of many superimposed structures which obscure detail. There is no need to obtain facial skeleton radiographs as an emergency unless the patient is going to undergo reduction of his facial fractures immediately.

The most useful single study is a Waters' view which requires that the patient be in a prone position. If the patient's condition precludes a prone position, reversed Waters' view may be substituted. Other views include the Townes, lateral mandibular views of the mandible and the mental-vertical view.

Repair of Small Lacerations

Following detailed evaluation of the patient and after injury to the facial nerve has been confirmed or ruled out, the laceration may be anesthetized by infiltration of a local anesthetic agent with or without added vasoconstrictor. Minimal discomfort to the patient ensues if the infiltrating needle is introduced via the wound itself rather than through the surrounding intact skin. The skin should then be cleaned with a mild surgical soap and the wound should be irrigated copiously with normal saline. After foreign material and necrotic tissue have been removed the wound may be closed in layers using absorbable suture material in the subcutaneous and dermal layers (4-0 or 5-0) and fine, non-absorbable material (5-0 or 6-0) in the skin margins. Emphasis is given to using the finest suture material possible while taking the smallest necessary bites of tissue. An unsightly and difficult-to-revise scar frequently results from the injudicious use of heavy suture material which is tied down tightly and left in place for long periods of time.

If for some reason, for example, the need for transfer to another hospital, closure cannot be attempted immediately, the wounds should be irrigated copiously with saline and dressed with saline-soaked sponges.

Repair of Facial Bone Fractures

Definitive reduction and fixation of facial bone fractures can be delayed in adults for 10 to 14 days, if necessary, without significant compromise to the long-term result. When either the mandible or maxilla is involved, the most important functional consideration is restoration of proper dental occlusal relationship. When these structures are involved, the teeth usually must be maintained in occlusion by some means of intermaxillary fixation for four to six weeks. A variety of techniques are available for internal and external fixation of mandibular and facial bone fractures, but a detailed discussion of these is not within the scope of this presentation.

Summary

Some principles in the initial evaluation and management of facial injuries have been presented. In the course of evaluating a patient with facial trauma, the presence of pre-existing disease or the possibility of non-facial injuries must be considered as an integral part of total patient management.

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Medical Grand Rounds

From the West Virginia University Hospital

Edited By
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Empty Sella Syndrome

Discussants:
Thomas Rapp
Fourth-Year Medical Student
Jehoon Peter Ko, M. D.
Assistant Professor of Radiology
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Assistant Professor of Neurosurgery
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A patient with an empty sella is presented. The disorder, which is diagnosed by pneumoencephalography or computerized tomography, is usually found in middle-aged, obese women. Although it may be associated with headaches, tests of pituitary function and visual fields are rarely abnormal. Clinical progression of signs or symptoms is uncommon and surgical or hormonal therapy is usually not required.

Mr. Rapp:

Case Report

This 62-year-old female Caucasian had a history of hypercalcemia and hypophosphatemia since 1970, with serum calciums ranging from 10.3 to 10.9 mg per cent and phosphorus from 1.9 to 3.7 mg per cent. She had remained asymptomatic except for nervousness, intermittent frontal headaches, dyspnea and a slight decrease in lateral visual acuity during the past year. She denied changes in skin, hair, weight or physical appearance, goiter, cold intolerance, weakness, hypertension, abnormal sweating, enlargement of the hands or feet, galactorrhea, or decrease in pubic hair. She had no renal stones or excessive ingestion of milk or antacids. In 1974, she had been on thiazides for a short period for congestive heart failure, but hypercalcemia continued after discontinuation of this medication.

In February, 1978, she was evaluated for persistent hypercalcemia and was found to have a serum calcium of 10.7 mg per cent and phosphorus of 2.6 mg per cent with an inappropriately high serum level of parathyroid hormone. She was admitted to another hospital where two of three calcium levels were normal, with one value of 11.1 mg per cent and a phosphorus of 1.9 mg per cent. Skull films, obtained for evaluation of her headaches, showed enlargement of the sella turcica which was confirmed by tomography. She was then transferred to the West Virginia University Medical Center for further evaluation.

Family history and review of systems were otherwise noncontributory. Medications included Digoxin, Lasix, Potassium, Librax and Motrin.

Physical examination showed generalized obesity. Blood pressure was 145/92 with a pulse of 90/minute. The thyroid was of normal size without nodules. Abdominal examination was difficult due to obesity but no organomegaly or masses were noted. The remainder of the examination was normal.

Admission laboratory included a normal CBC and differential with a sedimentation rate of 9 mm/hr. BUN 25 mg per cent, glucose 151 mg per cent and uric acid 9.0 mg per cent. Routine chemistries were normal. Serum calciums on three consecutive days were 10.7, 10.5 and 10.3 mg per cent with phosphorus levels of 2.9, 2.8 and 2.3 mg per cent respectively. T-4 was 9.1 mg per cent with a TSH of 5 mIU/ml. Creatinine clearance was 90 ml/minute and tubular reabsorption of phosphate was 80 per cent. Morning cortisol was 17.8 ug/ml and serum gastrin was 150 ug/ml (normal 0-150). Insulin hypoglycemia was attempted to evaluate pitui-

tary function but adequate decrease of blood glucose was not obtained. Plasma cortisol, however, increased from 7.4 ug/ml, baseline, to 11.9 at 30 minutes. Growth hormone levels remained less than 1.1 mg/ml. Visual fields done by ophthalmology were normal. Chest x-ray and hand films were normal. Skull films and tomograms showed a large sella and CAT revealed no mass lesion. Pneumoencephalography was consistent with an empty sella turcica.

Doctor Ullrich:

The disorder known as Empty Sella Syndrome is unlike most syndromes in medicine because it is usually discovered during evaluation of another problem. It may, in fact, have no associated clinical symptoms and be exclusively a radiologic diagnosis. Although it is occasionally accompanied by visual field defects and hypopituitarism, its primary importance is in differentiation from a pituitary tumor.

Definition

Empty sella syndrome may be defined as an extension of the subarachnoid space into an intrasellar location. This may be found after pituitary surgery or radiotherapy and then is known as secondary empty sella. The term, primary empty sella syndrome, is reserved for the spontaneous occurrence without any preceding manipulation; this will be discussed first.

Incidence

Busch[1] was the first to note that on some occasions the pituitary was smaller than usual and the remainder of the sella turcica was filled with cerebrospinal fluid. He studied 788 pituitaries at autopsy in patients without known pituitary disease, and noted this finding in five per cent. In seeking a possible explanation for these observations, he noted that the diaphragma sella was incompetent to some degree in 58 per cent. An opening in the diaphragm of greater than 0.5 cm was also noted in 39 per cent of 225 normal autopsies in another series.[2] It is generally believed that there must be a developmental anomaly, such as an incompetent diaphragm, for the empty sella to develop, but that the defect alone is not sufficient, because empty sella has not been found in infants.

The observations made at autopsy were soon confirmed radiologically with pneumoencephalography.[3] Since the syndrome was initially described, more than 240 cases have been reported.

Doctor Ko:

Radiologic Aspects

Empty sella is characterized by a spectrum of remodeling and nontumorous enlargement of the sella which contains subarachnoid space filled with cerebrospinal fluid. The pituitary gland is compressed to the floor inferiorly or posteriorly.

General agreement has been reached that one of the major etiologic factors in the empty sella is a deficiency of the diaphragm sella, specifically the type that forms only a peripheral rim. A postfixed optic chiasm may be an additional factor in that the contents of the sella are not protected from normal or sustained high pressure of cerebrospinal fluid pulsation by the optic chiasm. Although an empty sella can exist with a normal-sized sella, the diagnosis of the empty sella syndrome has been made by exclusion of the more ominous causes of sellar enlargement.

Usually, patients are referred to neuroradiology for detailed investigation because of the enlarged sella seen on a plain skull x-ray for some other reason; for example, for headache or head injury. Regarding sellar size, various measurements are commonly utilized; however, careful examination of shape and changes within the sella is also rewarding. Enlargement of the sella in empty sella syndrome differs in no specific way from enlargement caused by any other intrasellar mass.

After a plain film and clinical evaluation, a cerebral arteriogram is usually the next procedure performed to rule out other causes such as aneurysm or parasellar mass; and the definitive diagnosis of empty sella syndrome is only possible with pneumoencephalography or pantopaque encephalography.

When pneumoencephalography is performed, a deliberate attempt should be made to demonstrate the intrasellar subarachnoid space. It is necessary to position the head in such a way that the cerebrospinal fluid will leave the sella and air will enter. Often a tomogram is necessary to document the presence of air in the sella.

Association of the empty sella syndrome and spontaneous cerebrospinal fluid rhinorrhea has been reported. To demonstrate the bony defect, tomograms might be necessary; however, this is best diagnosed by a radioisotope cisternogram with ^{111}In DTPA. With advent of the CT Scan, a few retrospective analyses of the empty sella syndrome have been made and the results are promising. With the proper level of cut, a low absorption value (−8 to +12 or equal that of cerebrospinal fluid) within the sella is a charac-

teristic finding of empty sella; however, it is not specific since false positives have occurred due to a necrotic center in pituitary tumors. Further thinner slices using 5 or 7 collimator (presently a 13-mm collimator is commonly used) and analysis of absorption value might assist in differentiation of necrotic tumor and empty sella.

Doctor Ullrich:

Clinical Aspects

Weisberg *et al*[4] evaluated 100 consecutive patients prospectively who had an enlarged sella noted on skull x-rays. Skull x-rays had been obtained for a variety of reasons such as headache, endocrine symptoms, syncope, dizziness, sinusitis, seizures, arterial hypertension and rhinorrhea. Three patients with acromegaly and 22 patients whose primary complaint was related to visual impairment were excluded, leaving 75 patients for evaluation. Final diagnosis was determined by angiography, pneumoencephalogram or craniotomy. The final diagnoses were: primary intrasellar tumors, 27 patients; empty sella syndrome, 25 patients, and extrasellar process, 13 patients. No diagnosis was made in 10 patients because of omission of the air study. These 10, however, were followed up to three years without progression of radiographic or clinical findings, and most probably belong in the empty sella group.

Seventy-eight per cent of all the patients were women and all except one of those with an empty sella were women. Those with extrasellar processes were equally divided between the sexes.

Most of those with tumors and empty sellas were middle-aged.

Headache was a common clinical symptom in all groups and was the initial symptom in 25 per cent of those with an empty sella. Endocrine symptoms were the presenting complaint in two-thirds of patients with intrasellar tumors while none of those with empty sella syndrome had such symptoms. Seventy-six per cent of the empty sella group were asymptomatic, but two had rhinorrhea.

In those patients with an intrasellar tumor, amenorrhea, weight gain, infertility and galactorrhea were the most common endocrinologic symptoms.

Radiologic examination demonstrated that an enlarged, but normally shaped sella was most common in those patients with an empty sella, whereas the sella was usually enlarged with an abnormal shape in those with an intrasellar tumor.

Laboratory studies showed no abnormalities of the brain scan, EEG or spinal fluid examination in 13 patients with empty sella syndrome. These studies were frequently abnormal in patients with extrasellar tumors.

Evaluation of endocrine function demonstrated that 44 per cent of patients with empty sella syndrome had an inadequate response of growth hormone to insulin hypoglycemia. This may have been due to associated obesity (known to cause a blunted growth hormone response[5]), which was found in 24 of 25 patients. One patient also had an elevated prolactin, but other endocrine functions were normal in those tested. On the other hand, 20 of the patients with intrasellar tumors had abnormalities in at least one parameter of endocrine function.

Neelon *et al*[6] catalogued the clinical features (obtained by chart review) of 31 patients with primary empty sella syndrome. Most were obese, middle-aged women.

Hypertension was found in nine of 31 patients and headache was present in 71 per cent.

One patient had acromegaly, one had panhypopituitarism and three had partial pituitary insufficiency.

Another 12 patients with empty sella were reported by Jordan *et al.*[7] Eleven were women, which is similar to the preponderance of women found in other series. Eleven were overweight, 10 had severe headaches and seven had hypertension. Pituitary function testing showed that one patient had primary hypothyroidism, one had an elevated prolactin, and the other eight of 10 who were adequately tested were normal. The patient with primary hypothyroidism and elevated TSH also had decreased visual acuity.

These investigators also measured pituitary hormone levels in the cerebrospinal fluid of these patients. Elevation of adenohypophyseal hormones in CSF has been found in patients with suprasellar extension of pituitary tumors.[8] However, the levels of ACTH, TSH, GH, prolactin, LH and FSH were undetectable in all patients with empty sella syndrome.

Associated Disorders

Cushing's syndrome,[10] acromegaly[6] and amenorrhea-galactorrhea syndrome[11,12] have been reported in which an empty sella was found to co-exist with a hypersecreting pituitary tumor.

An unusual case was reported from Mexico in which a pregnant woman had pituitary involvement with cysticercosis associated with an empty sella.[13]

Benign intracranial hypertension, also known as pseudotumor cerebri, may be found in combination with empty sella syndrome. Berke *et al*[9] reported three of 19 patients with empty sella syndrome who also had benign increased intracranial pressure.

Five additional patients[14] with symptoms of severe headache for prolonged periods of time (six months to four years) also had empty sellas. These five patients accounted for only 10 per cent of 50 patients with pseudotumor cerebri seen at this hospital.

Eight patients with pseudotumor cerebri reviewed by Foley and Posner[15] also had empty sella syndrome. Four of these also had abnormalities of their visual fields.

Doctor Dunker:

Symptomatic Empty Sella

We have just heard an account of empty sella syndrome which for the most part is asymptomatic. This radiologic diagnosis is of greatest significance for what it is not. It is not a sellar enlargement which has resulted from an enlarging intrasellar mass such as a tumor, cerebral arterial aneurysm or an epithelial-cell-lined cyst.

There is another side to empty sella syndrome which may present as CSF rhinorrhea, trigeminal pain or progressive deterioration in vision. This symptomatic empty sella syndrome may occur spontaneously as a primary empty sella syndrome or it may follow either surgical or radiation ablative therapy for a pituitary adenoma and is, therefore, a secondary empty sella syndrome.

Treatment of CSF rhinorrhea is a medical imperative because of the high risk of meningitis associated with persistent CSF leakage. The preferred treatment is surgical obliteration of the subarachnoid-paranasal sinus communication. Ommaya *et al*[18] reviewed a combined United States and British experience with non-traumatic CSF rhinorrhea. Of eight cases which were not associated with intracranial tumors, they described two patients in whom a subarachnoid space-sphenoid sinus fistula was found within the sella turcica in association with a primary empty sella. Brisman *et al*[19] described four additional patients and Mortara and Norrell[21] described two similar cases. These authors explored the sellar region through a frontal or frontotemporal craniotomy, found an extension of the subarachnoid space into the sella which they amputated, and then obliterated the fistula by packing the sella with a piece of crushed muscle and fascia. Landolt[20] among others approached similar cases via a transnasal transsphenoidal exposure and filled the sella with fascia, cartilage and muscle, obliterating the sphenoid sinus and fistula from below.

Trigeminal neuralgia has been described in association with primary empty sella syndrome by Neelon *et al*[6] and by Landolt.[20] The mechanism by which empty sella syndrome is responsible for these pains is not known, but a causal relationship is suggested by Landolt's case, in which symptomatic relief was obtained only following transsphenoidal obliteration of the empty sella.

Progressive visual disturbances including decreasing visual acuity in one or both eyes, bitemporal visual field defects, and concentrically constricted visual fields have been described in association with empty sella syndrome. Mortara and Norrell[21] described four cases of progressive visual disturbances in association with primary empty sellas. In two instances, part of the suprasellar visual apparatus (optic nerves or chiasm) were found to be herniated into the enlarged sella through a deficient diaphragm sellae. Their treatment consisted of lysis of arachnoid adhesions and perforation of the lamina terminalis of the third ventricle.

These authors and a number of others[22] have described delayed progressive visual disturbances following surgical or radiotherapy obliteration of pituitary adenomas. They have observed a great tendency for adhesions to develop between the tumor capsule (or the diaphragm sellae) and the optic chiasm. With reduction in tumor mass, there is prolapse of the diaphragm sellae into the enlarged sella turcica and the optic chiasm is dragged along. Traction on the optic chiasm or optic nerve is felt to be responsible for the disturbance of vision. The preferred treatment is a chiasmapexy[17] or elevation of the prolapsed diaphragm sellae by packing the sella turcica with bone chips, muscle and/or fascia via a transsphenoidal approach. Careful attention to this aspect of the initial transsphenoidal surgical removal of a pituitary adenoma is stressed by Olson *et al*[23] and by Decker and Carras.[24] They emphasize that this is a preventable late complication of transsphenoidal pituitary surgery.

Symptomatic primary empty sella syndrome is a very uncommon entity, but it must be considered in any middle-aged, obese, multiparous woman with non-traumatic CSF rhinorrhea or pneumococcal meningitis, or a progressive visual disturbance of central origin. Symptomatic secondary empty sella syndrome usually comes to mind in cases of postoperative CSF rhinorrhea or

visual disturbances, but it must be considered and ruled out as a cause of late loss of vision following radiation therapy for a pituitary adenoma. Merely demonstrating the absence of a recurrent suprasellar mass is inadequate evaluation in such a case. The presence of an empty sella must be thoroughly excluded, because secondary empty sella syndrome constitutes a very treatable cause of post-radiation visual loss.

Doctor Ullrich:

Pathogenesis

Four theories of pathogenesis[6] of empty sella syndrome have been advanced:

1. Rupture of an Intra- or Para-sellar cyst.

Cysts containing fluid may result in enlargement of the sella and alterations of its contour. These cysts, however, are self-contained and rupture of the cyst would need to be postulated in order for communication with the subarachnoid space to occur. This sequence of events is not believed to occur spontaneously, but surgical removal of such a cyst may result in a secondary empty sella.

2. Infarction of sellar contents.

This mechanism may be involved in those patients who have hypopituitarism and empty sella. This may be more common in diabetics who are known to have an increased incidence of pituitary infarction. The presence of normal pituitary function in the majority of patients, however, suggests that significant pituitary necrosis is not present.

3. Pituitary hypertrophy and subsequent abiotrophy.

The occurrence of the syndrome predominantly in women, many of whom are multiparous, has suggested that it may be due to pituitary hypertrophy during pregnancy with subsequent involution, especially at menopause. It is known that the pituitary may double in size during pregnancy due primarily to an increase in prolactin-producing cells. However, in the series reported by Neelon,[6] there was no correlation between sellar size and number of pregnancies.

Pituitary enlargement has been reported in primary end-organ failure, such as hypothyroidism and hypogonadism. There is a direct correlation between size of the sella and the degree of hypothyroidism—as measured by serum thyroxine and TSH.[16] Replacement of the appropriate hormones might be expected to result in pituitary involution and may be responsible for some cases of empty sella syndrome.

4. Transmission of cerebrospinal fluid pressure through a congenitally defective sellar diaphragm.

This is the most commonly accepted theory of etiology. The necessity of a patent diaphragm presents no difficulty because this has been found in over half of normal persons at autopsy. An elevated CSF pressure may be found in pseudotumor cerebri, systemic hypertension, congestive heart failure and the Pickwickian syndrome. CSF pressure is not uniformly elevated in patients with empty sella syndrome, but in this obese, hypertensive population, it may be elevated intermittently and mildly. It is postulated that these long-standing, mild or intermittent elevations of pressure are transmitted through a patent diaphragm. This results in remodeling of the sella and flattening of pituitary tissue along the rim. The gradual progression is thought to account for the infrequent occurrence of involvement of the optic chiasm or hypopituitarism.

This theory does not account for those patients who are not obese or hypertensive and who do not have benign intracranial hypertension or any of the other disorders mentioned previously.

Acknowledgement

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The worst-tempered people I've ever met were people who knew they were wrong.

—Wilson Mizner

Special Article

Physician-Extender Education In West Virginia: The Physician's Assistant*

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The authors present an update of the status of physician-assistant (PA) education in the State of West Virginia with respect to curricular improvements, student profile, and graduate geographic and practice-setting distribution. Information regarding competency of the graduates of the American Medical Association-approved program, cost-effectiveness of the PA, and continuing medical education for PAs is also presented.

A decade in the training and education of PAs in West Virginia was completed with the 1977-78 academic year at Alderson-Broaddus College in Philippi. With the graduating class of 1977, the program had graduated approximately 180 PAs since its inception in 1968. The introduction of the program and the innovation of physician-extender education in West Virginia could not have become a reality without cooperation from the medical community in West Virginia (physicians, nurses, hospital administrators, and concerned health educators). After the tenth year of training for the PA, it appears appropriate to recap and to update progress of the program from its beginning until the present.

Definition of Physician's Assistant

The PA program at Alderson-Broaddus College holds very closely to the definition suggested and officially sanctioned by the American Medical Association which states that a PA is a "skilled person qualified by academic experience and practical, on-the-job training to provide patient service under the supervision and direction of a licensed physician who is responsible for the performance of that assistant." More generally, but considered as essential in the training of the PA, is the ability to develop competencies in the following areas:

1. The taking of a history and performing a physical examination in order to gather a data base.
2. Synthesizing of data gathered in order to present a clear picture of the patient's problems to the employing physician.
3. Identifying and recognizing normal and abnormal results of basic diagnostic procedures.
4. The assessment of data obtained in order to play an effective role in preparing the physician in his or her decision-making process.
5. The carrying out of determined treatment plans for common primary-care problems, including the answering of questions for families of patients and arranging for appropriate utilization of community resources.

In addition, it is considered important that PAs be able to apply specialized technical skills when needed, help in the management of inpatient care, and understand that by training and definition they *are not* to operate in an independent, but rather in a supervised fashion. In keeping with the initial philosophical intentions of the PA concept, competent clinical ability in the above cases cannot help but free the busy physician from the more routine aspects of patient care, resulting in the better delivery of health care.

Academic Nature of Program

In maintaining the tradition of being the first four-year program for the education and training of PAs in the United States, and the first four-year program to receive accreditation and approval from the AMA's Council on Medical Education, a vigilant watch has been placed on the quality of instruction and the evaluation of clinical competence of the program's graduates.

While the essentials of the program still remain within the rigorous guidelines of the council, there have been many refinements of indi-

*This paper was written while Doctor Hoffman was Acting Program Director, Physician's Assistant Program, Alderson-Broaddus College, Philippi, West Virginia.

vidual courses where it was felt that enrichment of the curriculum was needed. The original course in medical physics has been replaced by the requirement of a general course in physics for allied health professionals and a separate medical physiology course which stresses the relationships between basic mechanism and the clinical state.

The teaching of medical history-taking, which remains an academic strength of the program, is taught both in a classroom setting and in small group tutorial sessions. Here, instructors are able to work closely with students in answering questions, trouble-shooting problem areas, and providing role-playing situations which supplement student experiences with actual patients. On-the-spot evaluation of student performance of the physical examination by instructors has provided immediate feedback necessary for the development of clinical physical-assessment skills. The institution of a structured "clinical call" where students, under the supervision of an instructor, review various patients and are taught to understand complex management problems has been a recent innovation. As with many programs of this nature, the curriculum is viewed as a dynamic rather than a static entity which must constantly be revised and enriched with a basic framework.

The curriculum for the PA student has a four-year, integrated liberal arts-medical science approach. Students are trained not only to excel medically and to become competent practitioners in a medical sense, but the liberal arts curriculum, which includes religion, philosophy, social science and literature, has been designed to enable the PA to relate to the patient's wide range of human and spiritual needs. The first three years of the program are college-based, with the curriculum provided at the facilities of Alderson-Broaddus and Broaddus Hospital. On occasion, other hospitals are used but college faculty provides the instruction. At the aforementioned institutions, students receive didactic training in basic science courses, anatomy and physiology, microbiology, organic and inorganic chemistry, and mathematics and physics, as well as medical-science courses in physiology, pharmacology, pathology, clinical medicine, surgery and psychiatry. The fourth year of the program consists of a 48-week clinical experience of rotating preceptorships.

Within the last two years, the fourth year of the program has been enriched to include 12 months rather than the original nine months of preceptorship training. Presently, fourth-year PA students receive their clinical training at any one of six affiliated institutions: West Virginia University Medical Center at Morgantown; the Clarksburg Veterans Administration Hospital; the Martinsburg Veterans Administration Center; the Greater Southeast Community Hospital, Washington, D. C.; the Frederick C. Smith Clinic, Marion, Ohio; and the Medical University of South Carolina at Charleston. In addition, there are several participating physicians within the state who contribute their time and effort in training students in an eight-week private office practice preceptorship.

Program graduates are qualified to sit for the National Board of Medical Examiners' certification examination given in conjunction with the National Commission on the Certification of Physician's Assistants.

Utilization of 'Physician's Assistant' Title

In West Virginia, the title, "physician's assistant," is restricted for use by those individuals certified by the Medical Licensing Board of the State of West Virginia. The Type A PA as trained at Alderson-Broaddus is defined by Enrolled Senate Bill No. 168 enacted by the 1976 session of the West Virginia Legislature as being a person who:

(1) has graduated from an AMA-approved program;

(2) has successfully passed the National Board of Medical Examiners' Certification Examination for the primary-care physician's assistant (certified with the National Commission for the Certification of Physician's Assistants);

(3) shall be of good moral character.

Such an individual as defined above is limited in performance of patient-care services for which he or she is trained and which are consistent with the job description that the employing physician has outlined for the assistant and has submitted for approval to the Medical Licensing Board.

Student Characteristics

Students in the PA program have come from a varied background, both educationally and experience-wise. A profile of various characteristics in PA students who are now matriculating or who have graduated from the program is shown in Table 1.

Graduate Employment

As of January, 1977, there were 140 graduates of the PA program. These graduates are distrib-

TABLE 1

Profile of the Physician's Assistant Program (Students to Date)

Male	54%
Female	46%
Married	23%
Single	77%
Non-Resident	81%
West Virginia Resident	19%
West Virginia-Ohio-Pennsylvania tri-state area	48%
Previous educational experience prior to program	36%
Previous medical experience prior to program	59%
Average age at acceptance into the program	21

Modified after Edwards and Gallagher[1]

uted over 29 states (Table 2) with 28 per cent employed in West Virginia and 46 per cent employed in the West Virginia-Ohio-Pennsylvania tri-state area. Present available data indicates that 96.5 per cent are currently employed and only 3.5 per cent are currently unemployed (as indicated in graduate response to program questionnaires). Information obtained in January, 1977, indicated the practice settings for graduate PAs from the Alderson-Broaddus program (Table 3).

Originally envisioned as a health professional working only in the physician's office, PAs are now utilized in a variety of practice settings. Currently, 13 graduates are employed in Veterans Administration hospitals while another five

TABLE 2

Distribution of Graduate Physician's Assistants

Alabama	1	New Mexico	1
Alaska	4	New York	9
Arkansas	1	Ohio	13
California	4	Oklahoma	3
Colorado	4	Oregon	1
Connecticut	1	Pennsylvania	13
Florida	2	South Carolina	2
Kentucky	4	Tennessee	1
Indiana	3	Texas	4
Iowa	1	Virginia	5
Maine	2	Washington	1
Maryland	4	West Virginia	39
Michigan	5	Wisconsin	4
New Jersey	3	Unknown	2
Nevada	1	Medical School in Italy	1
New Hampshire	1		
		TOTAL	140

TABLE 3

Practice Setting

Group	63%
Solo	19%
Urban	40%
Rural	44%
Primary Care	58%
Specialty	31%
Unreported	10%
Other (graduate studies and teaching)	4%
Unemployed	3.5%

are finding excellent opportunities with federal and state correctional institutions.

Performance Standard and Certification

Not only is it necessary for the graduate PA to maintain a level of clinical excellence as dictated by his or her job description, but graduates who have received certification through the National Commission on the Certification of Physician's Assistants are expected to keep abreast continually of the latest developments in medicine. Upon passing the National Certification Examination, all nationally-certified PAs are required to accumulate 100 hours of continuing medical education credits every two years to qualify for reregistration as a PHYSICIAN'S ASSISTANT—CERTIFIED (PA-C). Most PAs regularly attend workshops, conferences, and special CME courses to maintain certification and further their medical education.

Conclusion

The introduction and the acceptance of the PA as a new health-care professional has gained a good measure of acceptance in West Virginia in the last nine years. The passage of Enrolled Senate Bill 168 in March of 1976 helped a great deal to clarify the role and the level of competency required of PAs to perform the patient-care services for which they have been trained. While some skepticism still exists regarding a PA's competency, hospital privileges, and liability, there appears to be an emerging consensus nationwide that an overwhelming percentage of employing physicians is satisfied with the PAs they employ.

Johnson *et al*[2] have reported that among 38 physician-PA teams studied in Florida, 63.2 per cent of the physicians felt that their PAs were well-trained, 28.9 per cent felt that they were adequately trained, and only 2.6 per cent reported that the PA was poorly trained. Similarly, 5.3 per cent of the physicians reported that the PA was over-trained. That the PA is a cost-

effective entity for the physician with a patient-volume overload is well documented in cost analysis studies by Record,[3] Ford,[4] and Moore.[5]

The cooperation and diligence of many physicians and organized medicine, as well as state officials have resulted in the viability of the PA concept in West Virginia, and the opportunity for improving the delivery of primary medical care to citizens of the state.

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Premature Infant Survival Rate Better

THE smallest premature infants—those from 2.3 to 2.8 pounds at birth after only seven months' gestation—have a much better chance of surviving and of growing up free of handicaps today than 15 years ago.

Premature delivery is the major contributor to infant deaths and health problems, according to Arthur E. Kopelman, M. D., East Carolina University Medical School, Greenville, North Carolina.

Writing in a recent issue of American Journal of Diseases of Children, Doctor Kopelman cites a study that found that only 5.1 per cent of pregnancies resulted in premature delivery, but these infants resulted in 85 per cent of all early deaths, excluding those due to fetal malformations.

At least two thirds of infants of 28 weeks' gestation can survive, the North Carolinia pediatrician declares. The great majority of these survivors will be normal. Perhaps 10 to 20 per cent will have disabilities, some of them handicapping.

All aspects of care for the small, sick premature infant have changed in the past 15 years, and it is virtually impossible to identify the factor or factors most responsible for the dramatic improvement, Doctor Kopelman said. Medical science has gained knowledge on the dangers of either too little or too much oxygen, chilling, malnutrition, acidosis, low blood sugar, and parent-infant separation, along with changes in management of these conditions.

111th ANNUAL MEETING

of the

West Virginia State Medical Association

The Greenbrier

AUGUST 23-26, 1978

PLAN NOW TO ATTEND

A message from . . .

The President

LET'S LOOK AT THE FACTS

RECENT remarks attributed to President Carter which called the American Medical Association the "major obstacle" to a better health care system in this nation drew responses representing varying degrees of anger and disappointment. One of the most kind bits of rebuttal described the Carter statement as "inaccurate." Often, it seems best not to dignify such an outburst by attempting a response.

At the very least, the remarks as reported by the media were intemperate as well as inaccurate. The AMA itself wrote a formal letter of protest to the President documenting very effectively its 131-year commitment of purpose, "to promote the science and art of medicine and the betterment of public health."

By pure coincidence, the President's attack hit the press in our state on the very day that the AMA was joining with the West Virginia University Medical Center's Charleston Division and the West Virginia State Medical Association in sponsoring, in Charleston, a day-long conference on "Air Pollution and Health Effects." Participants included representatives of industry, government, the legal fraternity and other parts of our society, as well as physicians.

Assuming new significance was a remark by one of the speakers that the AMA's first formal expression of concern about air pollution came in 1923, in the relatively early days of the automobile! Mr. Carter and his staff probably weren't aware of that, and maybe weren't too interested, anyway.

It does, however, help one's credibility, regardless of position, to be able to speak against a background of knowledge and fact.

JOSEPH A. SMITH, M. D., *President*

The West Virginia Medical Journal

Editorials

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author shall be held entirely responsible.

STUDYIN' ON IT

A man's almost got to believe what he sees and hears.

All them TV programs and newspapers must be right. It just costs too much to go doctorin' these days. Why should old Doc McCareful get all them x-rays and fancy tests just because me or the old woman or one of the kids got a burp caught crossed-wise? Chances are likely no more than one in a 100 that it's anythin' more than that. That's not bad odds and look at all the money it'd save for that inshurnce company. If we'd really get sick that'd be somethin' diffrunt.

The brass down at the plant are sure makin' a pitch to have us all join up in one of them there HMOs. They say it will keep me and the family healthy. That's sure kindly of them. I did hear tell from somewheres that HMOs is like gas rationin' when you're sick. I allow as how I didn't think much of that back durin' the war. Probbly just another one of them AMA lies. They say they're always lyin'. I'll have to ask old Doc McCareful. He don't lie.

They say it's cheap, though. I reckon the company could use the money. I expect, though, if I had another rupture like the last one they probbly wouldn't let me lay around the hospital like they did. Not much sense layin' around after they got you sewed up good and stout. It didn't hurt all that bad. I probbly could have gotten by athout them shots. If it would save a few dollars for the plant or the inshurnce company, who w'unt put up with a touch of the miseries? Only a weaklin' 'd complain.

It'd help my neighbor, too. Leave a little extra in the pot for him. He's sick a lot with that bad back. Can't do nothin' very good but rest. I like to tell you he sure does that good. Not his fault, though. Besides, a man's got to be neighborly.

The way that Mr. Carter goes on and that Senator Kennedy, too, the one that wants his job, would make you think the patriotic thing to do is to join up. I know they've both tried gettin' on a horse from the wrong side a time or two, but they can't be wrong all the time, can they? They're probbly lookin to save a few dollars so they can pass out a little extra in the Welfare checks. Not all of them is just lazy. Some of them needs it.

Them's the same two's been talkin' about the national health inshurnce. Socialized medicine, them AMA liars call it. Maybe I should ask old Doc what that socialized means. I know it's a dirty word. They say everythin' will be free. I'd have to study on that one for a spell. 'Peers to me like nothin's all that free. Leastwise, lookin' at my stub where it says taxes, seems like someone is spendin' some money somewheres. Might be they're all down there whoopin' it up and chasin' women like some of their buddies that got caught. Looks like the President ain't been able to sell them Congressmen and Senators on anythin', least of all gettin' born again.

Guess I'm just not smart enough to figure the likes of these. They're mighty complicated. I wonder if they need be. I sort liked it the way they was. But a body just can't be old fashioned about everythin'. That's bad, they say. I'll likely end up goin' along but I'm probbly agin it.

It's just that a right thinkin', neighborly, God fearin' and patriotic man couldn't go agin these now, could he? Maybe I'd best ask old Doc McCareful, just to be sure.

WHO REGULATES THE REGULATORS?

Who regulates the regulators? This question, heard more now than ever before, is easier to ask than to answer. Possibly there is no answer. It may be that we, the American public, have created a monster that we are unable to control. It could be that legislation which we perceive as protection for the public has been abused by those who implement the law. And what recourse is there? Those who carry out the "legislative intent" are relatively immune from our protestations.

Several weeks ago, Jack Anderson's syndicated column, "Washington Merry-Go-Round," de-

manded, "Regulator Agencies Require Regulation." In this expose, charges of financial interest in businesses regulated by government agencies were leveled at officials of these same agencies. Specifically named were the Federal Communications Commission, the Environmental protection Agency, and the Food and Drug Administration. It was noted that the first two agencies, when officials were caught with their hands in the cookie jar, made an attempt to correct the problem by better internal control. Not so the FDA.

H. R. Haldeman points out in his new book, *The Ends of Power*, that the federal bureaucracy in Nixon's administration was, and still is, out of control. There are overlapping agencies, each pursuing and executing independent goals with virtually no controls.

What has gone wrong? Surely we did not intend that these things would happen. The founding fathers would be horrified at what has become of the government they dreamed about and fought for.

Bureaucrats are not elected and therefore have little or no public accountability. But they do wield a great deal of power because they are the implementers. John Rineman, in a speech before the Dauphin County Medical Society several years ago, discussed this problem, giving as an example the Clinical Laboratory Act of 1972. "The purpose of this act was to regulate only clinical laboratories. It was not the intent of the legislature to intrude into the private offices of physicians," he said. Yet this is exactly what happened. Why? Because a zealous bureaucratic government carried out its own interpretation of the intent of this law. The key words are *what it interpreted*—not what the sponsors of the act intended, not what the legislature which passed the act intended, but how the regulators interpreted the law. The only recourse seems to be through the courts, a time-consuming and expensive method of determining what a law really means.

Government would have us assume that these regulations and regulators are saving us money and improving our social well-being, whether in medicine or environment or any other of a number of areas. One physician aptly observed that the government spends more money advertising that it is saving the public's money than it actually saves. Nothing from the government is ever free or inexpensive. The regulators are not a small part of that expense.

Aside from the courts, we can exert some influence at the ballot box, even if indirectly. The candidate who recognizes the need for limitations on the unnecessary size of the bureaucracy and who exhibits true concern about steadily increasing bureaucratic excesses deserves our support. Perhaps this is the issue about which we should care most.—*Pennsylvania Medicine.*

NEXT MONTH

The August *Journal* will be the annual Convention Issue. Most of the program material is in hand, including annual reports of committees. We'd like, in advance, to call your attention to the planned activities — business and scientific — at the Greenbrier.

We also hope that you'll be on hand, and that you've made the necessary reservations. The general sessions will provide a mixture of scientific and office management information. Affiliated section and specialty society officers have done their usual good work toward lining up attractive additional programs.

Our Readers Speak

What's In A Name?

As two of the more recent Ulster immigrants to this area, we are pleased to note the resurgence of interest about the influence of our earlier compatriots in the development of the Appalachian dialect. Within the space of a few days, we have been privileged to hear the interesting address on the origins of Appalachian English given by Ms. Wylene P. Dial of the West Virginia University Extension Service at the Scientific Session of the West Virginia Thoracic Society in Huntington, and to read the paper on "Mountaineer Personality Roots" by Dr. Greenbrier Almond in the May issue of this Journal. We have only one small crow to pick with Doctor Almond—we are Scots-Irish, not Scotch-Irish. "Scotch" is the name of a justly celebrated liquid import from the Celtic lands, and not the name of the people who created it!

Neither Ms. Dial nor Doctor Almond referred to the fact that the Ulster settlers of Appalachia were the original Hillbillies. In 1690, King William III of Orange ("of glorious, pious and immortal memory") defeated King James II at the Battle of the Boyne, thereby establishing the Protestant supremacy in Ireland. Many of the supporters of William and Mary, predominantly Ulster Presbyterians, emigrated to Virginia, where they were referred to as the Williamites or Billies. Those who settled in the hollows of what is now the Mountain State became known as the Hillbillies.

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GENERAL NEWS

Chicago, WVU Physicians Convention Speakers

Two additional speakers, Drs. Ruy V. Lourenco of Chicago and David J. S. Hunter of Morgantown, have been announced for the 111th Annual Meeting of the State Medical Association to be held August 23-26 at the Greenbrier in White Sulphur Springs.

Doctor Lourenco, Professor and Head of the Department of Medicine of the Abraham Lincoln

Ruy V. Lourenco, M. D.

David J. S. Hunter, M. D.

School of Medicine, University of Illinois, will speak during a "Symposium on New Methods of Treatment of Common Disorders" constituting the first general session on Thursday morning, August 24. His topic will be "Management of Chronic Pulmonary Diseases."

Speaking during the Friday morning general session will be Doctor Hunter, Associate Professor of Obstetrics and Gynecology, and Director of Fetal Maternal Medicine at West Virginia Medical Center. He will discuss "High-Risk Pregnancy."

Native Of Portugal

Doctor Lourenco also is Professor of Physiology both at the School of Basic Sciences and the Graduate College of the University of Illinois at the Medical Center, Chicago. He is Physician-in-Chief at the University of Illinois Hospital.

Doctor Lourenco was born in Lisbon, Portugal, where he received B.S. and M.D. degrees from the University of Lisbon. He took his initial training in Internal Medicine in Lisbon at the City and University Hospitals, and additional training in Respiratory Medicine and Physiology in Cologne, Germany.

Doctor Lourenco came to the United States in 1959, to Columbia-Presbyterian Medical Center in New York City where he completed four years of training in Internal Medicine and Pulmonary Medicine. He was the first Director of the Respiratory-Physiology Laboratory of the New Jersey College of Medicine in Newark, where he was an Assistant and Associate Professor of Medicine from 1963 to 1967.

He went to the University of Illinois in 1967 as an Associate Professor of Medicine and Physiology, Director of Respiratory Research at the Hektoen Institute for Medical Research, and Director of the Respiratory-Physiology Laboratory at Cook County Hospital. In 1969, he was also appointed Chairman of the Department of Pulmonary Medicine at Cook County Hospital and Professor of Medicine and Physiology at the University of Illinois College of Medicine.

Since 1970, he has been at the University of Illinois Hospital as the Director of the Pulmonary Section of the Department of Medicine. He was appointed Professor and Head of the Department of Medicine on July 1, 1977.

Respiratory Disease Specialist

Doctor Lourenco, an internist specializing in respiratory diseases, has published more than 100 papers in various scientific journals. His work has dealt mainly with the physiology and biochemistry of the respiratory system. He has contributed to the understanding of the cause of respiratory failure in emphysema and the effects of cigarette smoking on pulmonary defense mechanisms.

He has served as Chairman of the Scientific Assembly of the American Thoracic Society, as President of the Illinois Chapter of the American College of Physicians, and as a Councilor of the Central Society of Clinical Research.

Currently, he is a member of the Editorial Board of the Journal of Laboratory and Clinical

Medicine, a Director of the Chicago Lung Association and a Consultant for the Career Development Program of the Veterans Administration.

Doctor Lourenco is a Fellow of the American College of Physicians, the American College of Chest Physicians, and the American Association for the Advancement of Science, and a member of the American Society for Clinical Investigation and the American Physiological Society.

Oxford Professor

Doctor Hunter received his medical degree in 1963 from the University of St. Andrews School of Medicine in Dundee, Scotland, and was an Assistant Professor of Obstetrics and Gynecology at the Oxford University Medical School in England from 1970 to 1975. He joined the WVU staff in 1976.

Doctor Hunter is a Fellow of the American College of Obstetrics and Gynecology and a member of the Royal College of Obstetrics and Gynecology.

In 1966-67, he was a research Fellow in Reproductive Biology at the Worcester Foundation for Experimental Biology in Shrewsbury, Massachusetts.

His research interests are in the fields of carbohydrate metabolism in pregnancy and in gynecological endocrinology.

Other Program Information

Annual Meeting activities will get under way with a 2 P.M. meeting of the Association's Executive Committee on Tuesday, August 22; the usual pre-Convention meeting of the Council at 9:30 A.M. on Wednesday, and the opening session of the House of Delegates Wednesday afternoon.

As announced previously, Dr. Tom E. Nesbitt, President of the American Medical Association, will address the first House session.

Medical Economics Executive Editor James A. Reynolds, also as previously announced, will deliver the keynote, Thomas L. Harris Address at 9 A.M. opening exercises Thursday.

Additional speakers and other speakers announced earlier will be presented in a complete program wrap-up in the August issue of the *Journal.*

The general Convention format once again will provide opportunities for breakfast, luncheon and other meetings, of a scientific and/or business nature, of the various sections and specialty organizations affiliated with the Medical Association. It is anticipated that the bulk of these again will be scheduled on Friday (August 25).

Doctor Smith To Speak

Plans also call for the usual President's Reception on Wednesday evening, August 23, and the Saturday evening reception for new officers. The latter will follow the second and final House of Delegates session at 2:30 P.M. on Saturday which will bring the inauguration of Dr. Robert D. Hess of Clarksburg as President to succeed Dr. Joseph A. Smith of Dunbar. Doctor Smith will deliver his Presidential Address at the final House session.

The Annual Meeting of the Auxiliary to the State Medical Association, with Mrs. Joseph T. Mallamo of Fairmont in charge as the Auxiliary's President, again will run concurrently with the Association's Convention.

Marshall Announces Nine New Faculty Members

Nine new faculty members have joined the Marshall University School of Medicine, it was announced recently by Dr. Robert W. Coon, Dean.

These additions bring the school's teaching staff total to 42, Doctor Coon said, adding that several of the new staff members will share appointments with the Huntington Veterans Administration Hospital.

"When the school's faculty recruitment program is completed, we will have the equivalent of approximately 60 full-time faculty members, although the total number will be higher due to the sharing arrangement with the VA Hospital," Doctor Coon explained.

"In addition, we have a number of physicians from the area's medical community who have received clinical faculty appointments and who have volunteered to share their expertise by serving as medical educators on a part-time basis," he added.

The recent faculty additions include:

—Dr. David K. Heydinger, Associate Dean for Academic and Clinical Affairs; and Chairman, Community Medicine Department.

—Dr. Alexander Nies, Professor of Psychiatry, who also will be staff psychiatrist for the VA Hospital's Mental Health Clinic.

—Dr. James A. Coil, Associate Professor of Surgery.

—Dr. John A. Hunt, Associate Professor of Surgery, who also will be a staff surgeon at the VA Hospital.

—Dr. M. Paul Millet, Associate Professor of Anatomy.

—Dr. Cynthia E. Battiste, Assistant Professor of Pediatrics.

—Dr. Kenneth S. Scher, Assistant Professor of Surgery.

—Dr. Roger F. Leonard, Assistant Professor of Pharmacology, who also will be a staff clinical pharmacologist at the VA Hospital.

—Dr. William M. Schmitt, Assistant Professor of Family Practice.

Former ARH President

Doctor Heydinger formerly was of Lexington, Kentucky, where he was President of Appalachian Regional Hospitals, Inc. (ARH). He is responsible for coordinating the school's medical education program in the classroom and in the hospitals. His responsibility as Community Medicine Chairman is to develop programs oriented to the economic and sociological aspects of health care. A former Associate Professor of Clinical Anatomy at Ohio State University's College of Medicine, Doctor Heydinger was Clinical Professor of Surgery at OSU and Professor of Clinical Surgery at the University of Kentucky. A cum laude graduate of Maryville (Tennessee) College, he earned his M. D. degree from Western Reserve University School of Medicine.

A former faculty member at Dartmouth Medical School, Doctor Nies has been an Associate Professor of Psychiatry and Pharmacology at the University of Vermont College of Medicine. He earned his M. D. degree from McGill University in Montreal, Canada.

A graduate of Western Reserve University's Medical School, Doctor Coil has been Assistant Professor of Surgery at the University of Vermont with surgical staff appointments at the Medical Center Hospitals in Burlington and the Fanny Allen Hospital in Winooski.

Surgeon In South Africa

Doctor Hunt currently is Principal Surgeon at South Africa's Baragwanath Hospital, where he has held various surgical posts since 1964. He earned his medical degree from Witwatersrand University in South Africa.

Doctor Millet earned his Ph. D. degree in Anatomy from the Louisiana State University Medical Center Graduate School. He has been an Assistant Professor in the Anatomical Sciences Department of the University of Oklahoma's Health Sciences Center.

Currently completing a Pediatric Cardiology fellowship at the Mayo Clinic in Rochester, Minnesota, Doctor Battiste earned her medical degree from Northwestern University Medical School.

From Naval Center

A Lieutenant Commander in the U. S. Naval Reserve, Doctor Scher is staff surgeon at the Naval Regional Center in Philadelphia. He received his M. D. degree from the University of Pennsylvania School of Medicine.

Doctor Leonard, a medical graduate of the University of Virginia, is completing a fellowship in Clinical Pharmacology at the University of Vermont, where he also is a physical therapy instructor. He is emergency room staff physician at Northeastern Vermont Regional Hospital at St. Johnsbury.

Doctor Schmitt has been consultant to rural health centers for the North Carolina Department of Human Resources and will assist in the MU Medical School's Model Family Practice Center. He holds an M. D. degree from Loyola University.

Dr. J. Elliott Blaydes of Bluefield, left, Secretary-Treasurer of the West Virginia Academy of Ophthalmology and Otolaryngology, and Academy President, Dr. Trevelyn F. Hall II, Fairmont, center, accept the Greenbrier Conference Award—given in appreciation of the 31 years the group has met at the White Sulphur Springs restort hotel—from the Greenbrier's Director of Marketing, Peter W. Kipp. The Academy's 1978 annual meeting was held in April. New state officers who were elected are: Drs. Robert L. Dunworth, Huntington, President; Moseley H. Winkler, Charleston, Vice President - Ophthalmology; James L. Bryant, Clarksburg, Vice President - Otolaryngology, and Doctor Blaydes, Secretary-Treasurer.

Review A Book

The following books have been received by the Headquarters Office of the State Medical Association. Medical readers interested in reviewing any of these volumes should address their requests to Editor, *The West Virginia Medical Journal*, Post Office Box 1031, Charleston 25324. We shall be happy to send the books to you, and you may keep them for your personal libraries after submitting to *The Journal* a review for publication. *Meanwhile, please see review of the book, "Clinical Cardiology," on page xv.*—Editor.

Genetic Screening: Programs, Principles, and Research, by the National Academy of Sciences (Committee for the Study of Inborn Errors of Metabolism, Division of Medical Sciences, Assembly of Life Sciences, National Research Council). 388 pages. 2101 Constitution Avenue, N.W., Washington, D. C. 20418. 1975.

Review of Medical Microbiology, 13 Edition, by Ernest Jawetz, Ph. D., M. D.; Joseph L. Melnick, Ph. D.; and Edward A. Adelberg, Ph. D. 550 pages. Price $12. Lange Medical Publications, Los Altos, California 94022. 1978.

The Scientist: A Novel Autobiography, by John C. Lilly, M. D. 210 pages. Price $10. J. B. Lippincott Company, 521 Fifth Avenue, New York, New York 10017. 1978.

AMA's Washington Office: Its Work and Functions

Editor's Note: With ever-increasing, critical activity in Washington involving health care and related matters, the American Medical Association's staff there constantly must assume new duties and responsibilities. It's also vital that physicians throughout the nation understand the work and functions of the Washington office. The material below provides the best explanation we've seen to date of that operation.

Physicians feel frequently that the federal government is far too much involved these days in their profession's and patients' destinies.

Indeed, physicians can hardly be blamed for feeling this way.

Increasingly, Congress demonstrates its preoccupation with health and medical care by tinkering with it. Congress schedules and holds hearings; debates and passes bills; and functions overall so industriously that of the 25,000 or so measures introduced into each Congress, some 10 per cent bear directly or indirectly on health.

Once the new laws are on the books, the administrative agencies take over the business of implementation. That means that regulations must be drafted and argued and adopted.

Neither legislation nor regulation can be ignored. As true as it is that the power to tax is the power to destroy, so the power to regulate can be the power to paralyze, to strangle, and ultimately to destroy. Intelligently-drawn regulations can make poor laws workable and badly-drawn regulations can make good laws unworkable.

And so the symbiotic relationship on laws that exists between the legislative and the executive branches of the federal government demands unremitting vigilance.

The American Medical Association exercises that vigilance, and has since 1944, through a Washington Office.

Functions Of Office

The Washington Office has a number of functions:

- It is an intelligence-gathering organization, charged with the responsibility of staying abreast of Congressional thinking, planning and action; and with maintaining an equally close vigil on the doings of the various executive departments and agencies.
- It is a podium from which to disseminate AMA thinking on a variety of subjects of concern to government—AMA agreement, disagreement, caution, modification, proposed solution, or information to lawmakers and media alike.
- It is a mechanism for providing service to legislators and administrators; an on-the-spot AMA presence; a two-way conduit between those who make and administer the laws and the medical professionals who must live with the laws and try to make them work.

There is no perfect way for the Washington Office to go about its complex tasks. In consequence, neither table of organization nor administration method has remained immutable over the years. Efforts to increase the effectiveness of the Washington Office are always being made.

But in general, the Office works as a modestly staffed, highly specialized group of experts who serve as the extended arm of the AMA in Chicago.

Today, the Washington Office is a unit of the Division of Public Affairs, linked so closely with Chicago by tie-lines, teletype and thermofax that contact is continuous throughout the working day—and often goes on well after the day has ended.

Key People

Under the Washington Office Director and his deputy are these key people:

A director and four assistant directors of the Department of Congressional Relations. Between them, these five men cover all 535 members of Congress and their staffs; and work particularly closely with the staffs and members of those key committees through which the bulk of important health legislation must pass.

Each lobbyist is also assigned the responsibility of maintaining liaison with a number of state medical societies.

The Deputy Director of the Washington Office is also Director of the Department of Federal Affairs which works closely with the departments and agencies of the executive branch. Within this department are also two legislative attorneys who research major federal legislation affecting health; attend hearings; monitor the *Congressional Record* and the *Federal Register;* work closely with the Division's Legislative Department back in Chicago; touch bases frequently with the lobbyists; and help staff all meetings of the AMA's Council on Legislation.

Communications Department

A four-man Communications Department deals with media, covers the Washington scene for *AM News* and *JAMA*, helps Congressional staffs with research or speech material, etc.

Supporting all of this broad activity is the library, which serves staff, the general public, Congress and the federal agencies.

So much for the administrative unit: how does it work to reflect AMA policy?

First, the AMA's legislative objectives are set by its House of Delegates, usually in broad policy guidelines. These guide the AMA's Council on Legislation when the time comes for it to review the many and varied issues developing in government.

The Council then recommends to the Board of Trustees that legislation be proposed, supported, amended or opposed. Once the Board has acted, its decisions are sent to the Public Affairs Division for appropriate action in Chicago and Washington.

It is in this way that practicing physicians' viewpoints and supporting arguments are made known to the legislative and executive branches of government.

Important Component

By and large, this method has proved effective. Some AMA viewpoints are indeed rejected. But many are accepted; and many more help shape compromise positions.

The Congress usually welcomes AMA viewpoints because it recognizes that the public cannot be well served unless all portions of a question are carefully weighed. Thus, such independent forces as organized medicine contribute to the public weal by studying and questioning what government does and does not do.

In summation, the AMA-Washington Office is an important component of a complex mechanism designed to convey the individual American physician's viewpoint to the federal government.

October Cardiology Conference Scheduled At Greenbrier

A cardiology conference, "An Approach to Problems in Cardiology—1978, For the Physician in Practice," will be held October 25-27 at the Greenbrier in White Sulphur Springs.

The sponsors are the Council on Clinical Cardiology of the American Heart Association (AHA) and the University of Pittsburgh School of Medicine, in cooperation with the West Virginia Affiliate and Pennsylvania Affiliate of the AHA.

Objectives will be to provide: clinically applicable. recently delineated information concerning several common syndromes; an appreciation of the clinical application of testing methods, the indications for which appear to be changing; knowledge of reliable clues to specific diagnoses; and the individual attendees with an opportunity to clarify questions and discuss concepts with experts in a number of clinical topics.

The course will consist of a series of formal presentations and coordinated small-group workshops designed to bring the practicing physician up to date on certain important cardiology topics about which there is pertinent new information.

Guest Faculty

The guest faculty will include Drs. Robert J. Adolph, Professor of Medicine, Division of Cardiology, University of Cincinnati; Ernest Craige, Professor of Medicine, Division of Cardiology, University of North Carolina; W. Proctor Har-

vey, Professor of Medicine and Director, Division of Cardiology, Georgetown University; John A. Kastor, Professor of Medicine and Director, Division of Cardiology, University of Pennsylvania;

James J. Leonard, Professor and Chairman of Medicine, Uniformed Services University of the Health Sciences; Hyman W. Paley, Associate Clinical Professor of Medicine, University of California at San Francisco, and Director, Clinical Cardiology Laboratory, Mt. Zion Hospital and Medical Center, and William C. Roberts, Chief, Pathology Branch, National Heart, Lung and Blood Institute, National Institutes of Health.

Ten physicians from the University of Pittsburgh also will serve on the faculty.

Registration is limited to 120 physicians. The fee will be $175 for members of AHA Scientific Councils and $225 for non-members.

CME Accreditation

This continuing medical education offering meets the criteria for 15 hours in Category 1 of the Physician's Recognition Award of the American Medical Association provided it is used and completed as designed. The program also is acceptable for 15 Elective hours by the American Academy of Family Physicians.

Registrations, including area of practice, or specialty, and checks (payable to American Heart Association) should be sent to American Heart Association, 7320 Greenville Avenue, Dallas, Texas 75231, Attn: Scientific Sessions.

Reservations at the Greenbrier before August 15 are advised.

For additional information contact Virginia Harris, Program Director, American Heart Association, West Virginia Affiliate, 211 35th Street, S.E., Charleston 25304 (telephone 304/346-5381).

Promotions Awarded To 46 Of WVU School Of Medicine Faculty

Of the 133 faculty members at West Virginia University who were promoted or granted tenure, effective July 1, 46 are affiliated with the School of Medicine.

West Virginia Board of Regents approval of the WVU recommendations was announced by Jay Barton, Vice President and Provost for Academic Affairs, and Charles E. Andrews, M. D., Vice President for Health Sciences, who conducted detailed reviews within each college or school before making recommendations to the board.

The major criteria used are evidence of continuing professional development and outstanding performance in at least two of the three WVU functions—instruction, research and public service.

Advanced to the following ranks are:

Frances H. Adams, Clinical Assistant Professor, Neurology; Bernard N. Brady, Associate Professor, Anesthesiology; Paul B. Brown, Associate Professor, Physiology and Biophysics, granted tenure; Roy L. Butcher, Professor, Obstetrics and Gynecology; David A. Clayman, Associate Professor, Behavioral Medicine and Psychiatry; Howard D. Colby, Professor, Physiology and Biophysics; Janice W. Cone, Associate Professor, Behavioral Medicine and Psychiatry, with tenure.

John W. Cwik, Clinical Professor, Anesthesiology; Robert D'Alessandri, Assistant Professor, Medicine; Anthony DiBartolomeo, Associate Professor, Medicine; Donald C. Doll, Assistant Professor, Medicine; Anthony H. Entress, Associate Professor, Anesthesiology; Hubert R. Galford, Clinical Assistant Professor, Neurology; Beverly Ann Gryth, Clinical Assistant Professor, Neurology; Duane E. Haines, Professor, Anatomy; Charles L. Harris, Associate Professor, Biochemistry, with tenure; Andrew C. Heiskell, Clinical Assistant Professor, Surgery; Bette Gabbard Hinton, Clinical Assistant Professor, Community Medicine.

Michael B. Howie, Associate Professor, Anesthesiology; Stanley J. Kandzari, Professor, Surgery; Sam Katz, Professor, Biochemistry; Dharmendra Kumar, Assistant Professor, Radiology; David P. Lee, Clinical Associate Professor, Medicine; Mary Lou Lewis, Clinical Professor, Medicine; Daniel B. MacCallum, Clinical Assistant Professor, Medicine; William O. McMillan, Jr., Clinical Professor, Medicine; Elmaslias Menchavez, Clinical Assistant Professor, Pediatrics; Richard A. Moran, Clinical Assistant Professor, Neurology; Alfreda Munoz, Clinical Assistant Professor, Pediatrics.

Phillip J. Peters, Assistant Professor, Medicine; Martin Reiter, Clinical Professor, Medicine; Ole Renick, Assistant Professor, Surgery; Joseph

Renn III, Clinical Associate Professor, Medicine; John J. Rick, Associate Professor, Anesthesiology; Ronald R. Scobbo, Associate Professor, Medicine; Richard J. Seime, Associate Professor, Behavioral Medicine and Psychiatry; Jeffrey S. Shultz, Associate Professor, Medicine, with tenure; L. Dale Simmons, Clinical Professor, Family Practice; F. T. Sporck, Assistant Professor, Surgery.

Anne W. Sharpe, Assistant Professor, Pathology, with tenure; Kathryn R. Stanko, Clinical Assistant Professor, Neurology; Eugene L. Staples, Clinical Professor, Behavioral Medicine and Psychiatry and Community Medicine; Lois V. Svoboda, Assistant Professor, Family Practice (part-time); Irma H. Ullrich, Associate Professor, Medicine; Richard Wanderman, Clinical Associate Professor, Pediatrics, and Patrick C. Williams, Clinical Associate Professor, Obstetrics and Gynecology.

AMA Files Suit Against Release Of Medicare Lists

The American Medical Association was granted early in June a request for an order temporarily restraining Joseph A. Califano, Secretary of the United States Department of Health, Education, and Welfare from making public a list identifying each physician who provided services and the amount of Medicare payments purportedly generated by him or her in 1977 to beneficiaries of the Medicare program.

In the action before Judge Roszkowski of the United States District Court for the Northern District of Illinois, Eastern Division, the AMA noted that publication of this list would invade the constitutionality and statutorily-recognized interest of each such physician in the confidentiality of information relating to personal income. Release of names would further call into question the integrity of the physicians, and would deter physicians from treating Medicare beneficiaries in the future.

Irreparable Damage

The Association pointed out that once the list is made available to the public, plaintiffs will suffer irreparable damage, yet Secretary Califano would lose nothing by waiting to release the list until the complex legal issues it raises are resolved.

Robert B. Hunter, M. D., Chairman of the AMA Board of Trustees, and one of the plaintiffs, said, "It is unfortunate that Mr. Califano persists in releasing these lists at all. In the past this has led to irreparable harm to the plaintiffs because when made public, the implication has been that physicians receiving high incomes under the Medicare program have been suspect. The release of these lists is an expensive exercise that has not been proven to have any beneficial effect on the operation of the Medicare program." Other plaintiffs are: Frank J. Jirka, M. D., Vice Chairman of the AMA Board of Trustees, Lowell H. Steen, M. D., Member of the AMA Board of Trustees, Harold Gurgone, a patient of Doctor Jirka, and Walter E. Schrage, a patient of Doctor Steen.

Erroneous Impression

In related cases, orders temporarily restraining the release of lists were issued earlier in Florida and Louisiana. In the Florida case, a special magistrate recommended that "Plaintiffs' motion for a preliminary injunction should be granted."

In supporting memorandum, the AMA reviewed the circumstances of the release of the previous list for 1975 that was so riddled with errors the Secretary of HEW had to withdraw it and disseminate a revised version. The 1977 list may also be inaccurate. However, even if accurate, the Association says, the figures give the erroneous impression that certain physicians are "gouging" the public by receiving improper or otherwise questionable payments from the Medicare program.

Court Petitioned On FTC Ophthalmic Ruling

The American Medical Association has petitioned the Federal District Court in Washington, D. C., for judicial review of the recently-issued Trade Regulation Rule on the provision of eyeglasses, contact lenses, and eye examinations.

In its petition, the AMA questioned the authority of the Federal Trade Commission to issue Trade Regulations that pre-empt constitutional state laws and ethical standards of private associations without regard to the reasonableness of any particular standard.

The Rule in question was issued by the FTC on May 24, 1978. It pre-empts state laws on the advertising of prices for eyeglasses, contact lenses, and eye examinations, and requires that consumers be provided with a copy of a written prescription for eyeglasses or contact lenses on request.

In commenting on the petition, James H. Sammons, M. D., AMA Executive Vice President, emphasized that, "the issue is whether an executive federal agency can substitute its judgment as to what is unfair competition for that validly exercised by state legislatures. The Supreme Court has already invalidated state laws prohibiting the advertising of health care services, and the AMA has endorsed the non-deceptive advertising of physician services. The Association has specifically stated that the public is entitled to useful information so that patients can make an intelligent and informed choice."

The rule also prevents professional societies from setting membership standards limiting the release of false and deceptive information concerning ophthalmic goods and services.

Major Impact

Doctor Sammons also noted that the AMA has a long-standing position that the patient is entitled to a copy of his or her prescription, and is entitled to have the prescription filled wherever he or she chooses.

Judicial affirmation that the Federal Trade Commission has the power to pre-empt state laws governing the practice of medicine would have a major impact on the provision of medical services. The FTC rule on ophthalmic goods and services primarily affects ophthalmologists and optometrists.

In issuing the rule, the FTC maintained that Congress has given the Commission rule-making authority to prevent unfair methods of competition and unfair or deceptive acts or practices. The Commission anticipated that the rule would be the subject of a court challenge. The Americans for Democratic Action and the American Optometric Association have also filed suits against the Commission in the U. S. Court of Appeals in the District of Columbia.

MEDICAL WRITING

Experienced medical writer with pharmacy degree will ghostwrite, rewrite, edit or proofread technical or general papers, articles, textbooks, handouts, educational materials etc. Local references available, fees mutually agreed before work commences. J. Marion Anderson, 90 School St., Morgantown WV 26505. Telephone 304-599-9319.

Medical Meetings

July 21-25—Am. Assn. for Clinical Immunology & Allergy, Newport Beach, Calif.

July 27-29—Recent Advances in the Pathology of Breast Cancer, Santa Fe, N.M. Info: W. J. Levy, M. D., P. O. Box 5175, Santa Fe 87502.

Aug. 16-19—Vascular Disease—Mechanisms and the Basis for Therapy (Am. Heart Assn.), Hilton Head, S. C.

Aug. 23-26—111th Annual Meeting, W. Va. State Medical Assn., White Sulphur Springs.

Sept. 10-14—Am. Academy of Ophthalmology & Otolaryngology (Otolaryngology Section), Las Vegas.

Sept. 19-21—Am. College of Emergency Physicians, Houston.

Sept. 21-23—Cardiology for the Clinician (Am. Heart Assn.), Williamsburg, Va.

Sept. 22-24—Am. Neurological Assn., Washington, D. C.

Sept. 24-28—Kentucky Med. Assn., Lexington.

Sept. 24-30—Am. College of Gastroenterology, Denver.

Sept. 25-28—AAFP, San Francisco.

Sept. 29-30—AMA Medical Staff Leadership Seminar, New York City.

Sept. 29-30—ASIM, Orlando, Fla.

Oct. 22-25—Indiana State Medical Assn., Clarksville.

Oct. 22-26—Am. Academy of Ophthalmology & Otolaryngology (Ophthal. Section), Kansas City, Mo.

Oct. 25-27—Cardiology Conference (Am. Heart Assn., University of Pittsburgh, W. Va. & Pa. Affiliates, AHA), White Sulphur Springs.

Oct. 25-29—Am. Academy of Child Psychiatry, San Diego.

Oct. 27-29—D. C. Medical Society, White Sulphur Springs, W. Va.

Oct. 30-Nov. 1—Pa. Med. Society, Lancaster.

Nov. 2-5—Med. Society of Virginia, Williamsburg.

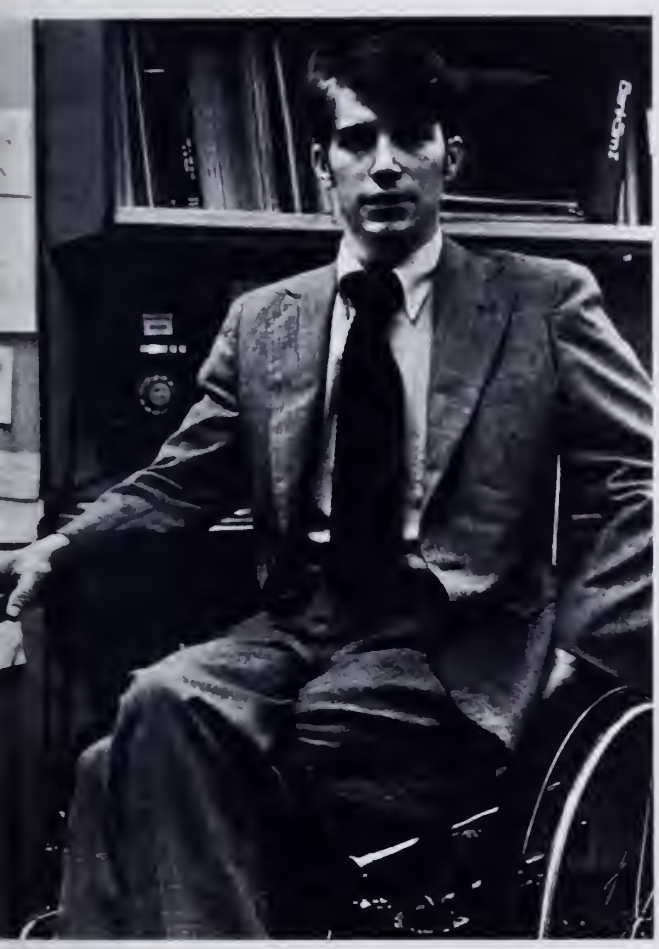
Nov. 11-14—Southern Medical Assn., Atlanta.

1979

Jan. 26-28—12th Mid-Winter Clinical Conference, Charleston.

March 30-April 1—W. Va. Chap., AAFP, Charleston.

Ed Scherer was promoted recently
the Federal Reserve Bank.
He is paralyzed from the waist down.



Ed Scherer broke his neck the sum-
after his senior year in high school.
as diving over a guy's head, "Scherer
ains. "I hit the water wrong and was
alyzed from the waist down." Scherer
in the hospital for six months. When
got out he applied to and was accepted
he University of Illinois, one of the
st accessible schools in the world for
bled students. While at college he
ed as chairman of a committee help-
to eliminate architectural barriers on
campus. He was Editor-in-Chief of Sigma
Signs, the publication of the school's dis
abled student's organization. One of the
purposes of Sigma Signs, in the words o
Scherer's 1974 editorial, is to show the
non-disabled that "the old myths are
wrong—the disabled can be productive
and accomplished people." His own ca-
reer provides ample proof of that. "The
Department of Vocational Rehabilitation
paid my college tuition," says Scherer,
"but I didn't use their help to get a job." In
stead, after receiving his Masters at
Adelphi University, he went job-hunting o
his own. He was subsequently hired by th
Federal Reserve Bank as an adminis-
trative assistant in the Cash Department
Recently he was promoted to research
assistant in the Banking Studies
Department.

Scherer is a member of the National
Paraplegic Foundation, an organization
promoting research on spinal cord in-
juries. Ed and his wife Carroll, who is not
disabled, have been married about a yea

Things are more difficult for the dis-
abled, but, in Scherer's words "with a litt
guidance, many supposedly insurmount
able problems can be overcome, and
many of our dreams fulfilled."

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Maternal-Infant Care Teams In Community Hospitals

An inservice program designed to support maternal and infant care in community hospitals is now being conducted by nurse-physician teams from WVU Medical Center and the state's other Level III (referral) medical facilities.

Covering the northern and eastern counties, the WVU team is responsible for approximately 30 hospitals. Teams from the Charleston Area Medical Center and Cabell-Huntington Hospital are covering southern West Virginia.

Part of the program for improving pregnancy outcome (IPO), the inservice training sessions are funded through a four-year $350,000 federal grant to the West Virginia State Health Department through Title V of the Social Security Act, Maternal and Child Health Services.

The initial visits of the WVU team were expected to be completed in June with follow-up visits scheduled for July and August and at such other times as specific needs arise.

"We want to share our knowledge with them in an inservice program much like the Infant Resuscitation Program which was conducted last year by a team from the Department of Pediatrics," said Ann Dacey, perinatal nurse educator in the School of Medicine's Department of Obstetrics and Gynecology and a member of the WVU team.

Like maternal and infant transport and newborn intensive care units, these programs are among steps recommended by the Committee on Perinatal Health to bring West Virginia's newborn mortality rate in line with the national average.

West Virginia's newborn mortality rate, while declining appreciably over the past 10 years, is 10 per cent higher than that of the nation, according to 1976 statistics.

Mothers considered at high risk are often referred to prenatal care and/or delivery to hospitals equipped to take care of special problems, Ms. Dacey said.

Identification of any problem which may pose a high risk to either the mother or her infant is one of the major items being discussed during the inservice training. Included is an explanation of "high risk scoring" which, if properly applied, can warn practitioners of serious complications far in advance of labor or delivery.

Mothers at high risk include those who have high blood pressure or diabetes, those who have lost a child during a previous pregnancy or during the first week of life, are more than 35 or less than 15 years of age, or have problems during pregnancy, according to David J. S. Hunter, M. D., Associate Professor of Obstetrics and Gynecology in the School of Medicine and perinatologist with the WVU team.

Constant Hypertension Watch Needed For Public

It will take more than screening programs to de-fuse the time bomb of high blood pressure, according to WVU cardiologist Abnash C. Jain, M. D.

"Screening programs are fine as far as they go," he said, "but more are needed on a continuing rather than a sporadic basis.

"Unless medical follow-up is assured and the public educated about the prevalence and treatment of high blood pressure, detection does little to solve the overall problem."

Doctor Jain, Professor of Medicine, has been actively involved with the blood pressure screening program of the American Heart Association. He is President of its West Virginia Affiliate.

"It is estimated that there are from 20 to 30 million adults in the United States affected with hypertension," he said. "Of this number, only about 60 per cent are aware they have high blood pressure. Of those who are aware, only about half are receiving adequate treatment.

"One of the problems in treating high blood pressure is that it is hard to convince people they need constant therapy when they are without symptoms."

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Third-Party News, Views and Program Concerns

Local Level Planning Urged By AMA Official

Health planning "cannot be stereotyped from federal blueprints," an American Medical Association official told the National Journal Conference on Health Policy recently in Washington, D. C. Frank J. Jirka, Jr., M. D., Vice Chairman of the Board of Trustees, said the best way to uphold availability and quality is to have planning decisions made at the local level. He said practicing physicians should be well represented on planning bodies.

Complaints about the planning guidelines that recently went into effect "keep pouring into HEW headquarters and now exceed 70,000," Doctor Jirka said. He noted that the guidelines "are still mandatory . . . in a way that runs counter to Congressional intent." The standards ignore many of the realities of medical care . . . and could cause substantial disruption in the accessibility and provision of health services."

Addressing the same conference, Rep. Dan Rostenkowski (D-Ill.), Chairman of the House Ways and Means Subcommittee on Health, said the federal tax structure encourages inefficiencies in health care and should be reviewed by Congress. He said the Internal Revenue Service code provides incentives for "patterns or practices which may be quite contrary to the efficient financing of quality health care." Hospital construction grants, interest subsidies, loans, and loan and mortgage guarantees will total $678 million this year, he said.

Public Health Education Bill Introduced

Legislation to promote disease prevention and instruct the public on good health practices has been introduced in Washington by Sen. Edward Kennedy (D-Mass.). The bill would provide grants to states for programs aimed at the five leading causes of death and disability, grants to private and public entities for health promotional campaigns, and technical assistance to state and local health promotion efforts. It also calls for nutritional labeling on all foods and a comprehensive antismoking campaign.

The plan for such legislation was first announced last January when Kennedy addressed the American Medical Association's National Leadership Conference. AMA Trustee Lowell H. Steen, M. D., appearing with Kennedy on national television, said the Association is "basically supportive" of the legislation. Although the AMA has "some reservations" about certain provisions in the bill, Doctor Steen said, some of the programs are "things that the AMA has been advocating for many years."

The bill calls for spending of $150 million the first year and $300 million annually in later years. Kennedy told the Senate that health promotional programs "cannot work if they are imposed from above." He said they "must be based firmly in the communities of America. They must involve state and local government, labor and industry, voluntary groups, school systems, physicians, hospitals, health centers, and individuals in their places of work and in their homes."

AMA-Kennedy Conference

The American Medical Association-Kennedy joint conference focusing on positive health strategies, July 25-27 at the Shoreham Hotel in Washington, will open with an address by AMA President Tom E. Nesbitt, M. D. Other speakers will include Sen. Edward Kennedy, AFL-CIO President George Meany, and UCLA School of Public Health official Lester Breslow, M. D. Additional guest speakers and participating panelists will examine programs for good health implemented in schools, communities and work places. Participants will also discuss health action programs that need to be developed in the future.

For information, write AMA-Kennedy Joint Conference, Office of Executive Vice President, AMA Headquarters.

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County Societies

McDOWELL

The McDowell County Medical Society met on May 10 at Stevens Clinic Hospital in Welch.

The guest speaker was Dr. Nancy C. Wanderman, pediatric cardiologist at the Charleston Division, West Virginia University Medical Center, who spoke on echocardiography.—Muthusami Kuppusami, M. D., Secretary.

* * *

MONONGALIA

The Monongalia County Medical Society met on May 2 at the Old Mill Club in Morgantown.

The speaker for the scientific program was Dr. Kjell Dahlen, ophthalmologist at the West Virginia University Medical Center. His topic was "Diabetic Retinopathy and Laser Photocoagulation."—Barbara Jones, M. D., Secretary.

* * *

TYGART'S VALLEY

The Tygart's Valley Medical Society met on April 20 at Mellie's Restaurant in Philippi.

The speaker for the evening was Dr. Donald W. Cox, Associate Professor of Gynecology, West Virginia University School of Medicine, who spoke on "Endometriosis."

Blue Cross and Blue Shield presented a movie on "The Buck Stops Here—The Physician must be a Decision-Maker in Lowering Health Costs."—A. Kyle Bush, M. D., Secretary.

* * *

FAYETTE

The April meeting of the Fayette County Medical Society was held jointly with the Auxiliary on April 15 at the White Oak Country Club.

The program, arranged by the Auxiliary in recognition of the annual "Doctor's Day," was presided over by the President, Mrs. Carl R. Adkins of Fayetteville. In the course of the program the Auxiliary honored Dr. Ivan H. Bush, Jr., of Oak Hill as the Fayette County "Doctor of the Year."

The May meeting of the Society was held at Montgomery General Hospital on May 3. Dr. Robert E. O'Connor, Charleston ophthalmologist, was the guest speaker. His topic was "Differential Diagnosis of the Red Eye."—Joe N. Jarrett, M. D., Secretary.

Answers To Review Article Questions

(Questions on Page 155)

1. — 2	6. — 1
2. — 3	7. — 1
3. — 2	8. — 1
4. — 2	9. — 4
5. — 4	10. — 5

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Book Review

CLINICAL CARDIOLOGY—Maurice Sokolow, M. D.; and Malcolm B. McIlroy, M. D. Lange Medical Publications, Los Altos, California 94022. 659 Pages. 1977. Price $16.

The text, *Clinical Cardiology*, which is a summary of the 20 years' experience of Doctors Sokolow and McIlroy, is a good book—an inexpensive reference for medical students, medical residents, family practitioners and practicing internists. It would be helpful for those preparing for their boards in family practice or internal medicine.

The book surveys the entire field of cardiology, with several of the chapters deserving particular notice. Outstanding were the chapters on Systemic Hypertension and Cardiomyopathy. The treatment of valvular heart diseases, cardiac failure, congenital defects and rhythm disturbances was adequate. There were two special chapters, Heart Disease in Pregnancy and Heart Disease in Surgery, which contained useful information for someone who does not manage these problems on a daily basis. The chapters on Physiology of the Circulatory System, History-Taking, Physical Examination and Clinical Physiology were also very good.

The graphs and line drawings in the book are uniformly good and the book is amply illustrated. Photos, however, are of variable quality. The writing is lucid and the design of the book is clearly outlined.

The chapters on Invasive and Noninvasive Investigations seem superficial and inadequate for someone interested in the field. The handling of electrocardiograms was disappointing, and the reader frequently is referred to the companion volume on electrocardiograms in the Lange series.

The text could have been an outstanding reference if electrocardiograms had been treated as a more integral part of cardiac diagnosis rather than being relegated to a "special procedure" in the province of the electrocardiographer.

In summary, the book is useful for those who desire a general reference and survey of the field of cardiology. The quality of the writing also makes the book—for the price—a bargain.—Beverly Yamour, M. D.

AMA Has New Committee on Services to Young Physicians

The AMA now has an Ad Hoc Committee on Services to Young Physicians. Objectives of the 11-member group are to determine the needs of young practicing physicians in order to recommend the modification of existing AMA activities and creation of new services.

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The West Virginia Medical Journal

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The West Virginia Medical Journal

Vol. 74, No. 8 August, 1978

Long-Term Survival In Multiple Myeloma

A. RAFAEL GOMEZ, M. D.
Chief, Section of Hematology, Department of Medicine, Charleston Area Medical Center, Charleston, West Virginia; and Clinical Instructor, Medicine, Charleston Division, West Virginia University Medical Center.

A case report of multiple myeloma with a survival of 10 years is presented with discussion of the various clinical parameters as related to prognosis. Emphasis is placed on the role of effective chemotherapy on the course of the disease. Given a case that meets the criteria of a good-risk category, a high degree of remission and prolongation of survival should be expected. With the advent of new and more effective chemotherapeutic agents and with better understanding of their usage, the physician has the hope of prolonging the life expectancy in a given case of multiple myeloma.

It is believed that multiple myeloma is preceded by an asymptomatic period of variable duration during which time the only findings could be an elevated sedimentation rate, an M-component in the serum electrophoresis, or an unexplained proteinuria. The presenting features of bone pain, backache, and anemia are seen in more than 90 per cent of the cases.[1] Other prominent features are recurrent infections, weakness, weight loss, gastrointestinal infiltration with bleeding, soft tissue mass, retroperitoneal involvement, and unexplained renal failure.

Prior to 1960, patients with multiple myeloma had a median survival of 17 months from the onset of symptoms and seven months from the onset of therapy. With the advent of modern chemotherapy, a greater remission rate and prolongation of useful life have been obtained. A patient was reported to have been followed for 30 years; however, this case was one of plasma cell solitary lesions, with dissemination and without any involvement of the marrow throughout the osseous tissue. According to the same author, there were no references in the literature to other patients with solitary or multiple myeloma who had survived 30 years or more.[2]

Clinical Parameters

Once a diagnosis of multiple myeloma has been established, a variety of clinical parameters documented before the onset of therapy are analyzed to determine survival time of patients with this disease. The following parameters have been found to have an effect on prognosis: age, anemia, hypercalcemia, azotemia, and myeloma protein levels.[3]

There is an adverse effect on survival for patients over 65, for those with the presence of severe anemia with hemoglobin less than 8.5 grams per cent, for those with hypercalcemia (calcium levels above 12.5 milligrams per cent), for those with the presence of a BUN greater than 40 milligrams per cent, and for those with an albumin of less than three grams per cent. These parameters indicate a median survival time ranging from 13 to 20 months. They were compared with the median survival of patients under 55, those with a mild degree of anemia with a hemoglobin of more than 10.5 grams per cent, those with a calcium level less than 11.5 milligrams per cent, those with a BUN less than 40 milligrams per cent, and those with albumin equal to or more than four grams per cent. These patients had a median survival ranging from 25 to 31 months.

Reported In Younger Adults

Multiple myeloma has been considered a disease of the elderly; however, cases are being reported in younger adults, even in their later teens and twenties.[4] The life span has been prolonged in these cases (longer than 71 months from diagnosis), and it is postulated that a

superior immuno-surveillance capacity may be associated with myeloma in very young persons.

A correlation between prognosis and the type of immunoglobin has been reported. The prognosis for patients with IgA is worse than for those with IgG myeloma, with death occurring within one year of diagnosis in 57 per cent of the former and in 21 per cent of the latter.[5] It is believed that myeloma of the IgA type represents a more extensive or more quickly growing tumor with more serious complications, i.e., renal damage, bone lesions and hypercalcemia.

Other adverse prognostic signs are amyloidosis, bone lesions distal to the elbows and knees, pathological fractures of the sternum, proteinuria greater than 40 per cent, and the presence of Bence Jones proteinuria.

Good Risks

Considering the above parameters, patients with multiple myeloma have been divided into good-risk and poor-risk categories. The criteria for good risks are as follows: BUN equal to or less than 30 milligrams per cent, serum calcium equal to or less than 12 milligrams per cent, absence of significant infection at onset of study, white blood count equal to or over 4,000 per cubic millimeter, platelet count equal to or over 100,000 per cubic millimeter, and estimated survival of more than two months. Patients who fail to meet one or more of the above points are in a poor-risk category.

Treated With Melphalan

Good-risk patients treated with melphalan alone have a median survival of 30 months as compared with poor-risk patients with a median survival of 20 months. The addition of prednisone to melphalan increased the median survival in good-risk patients to 53 months.[6]

In an analysis of prognostic factors in 866 cases of multiple myeloma from the Mayo Clinic, serum creatinine and serum calcium levels were the most significant factors affecting the two-year survival. The median survival was 20 months. The survivorship was 65 per cent at one year, 32 per cent at three years, and 18 per cent at five years.[7]

We next would like to report a patient with multiple myeloma who has survived for 10 years. This case illustrates some of the presenting features of multiple myeloma which may mimic other medical conditions and delay its recognition.

Case Report

This is a 52-year-old white, married male who, in October, 1967, began to complain of back pain. In May, 1968, medical work-up at the Charleston Area Medical Center suggested a filling defect at myelography. A laminectomy of L-1, L-2, L-3 was carried out and the pathological diagnosis was multiple myeloma. A bone marrow aspirate showed 44 per cent plasma cells. A roentgenographic bone survey showed destruction of the pedicle of the second lumbar vertebra on the left, and destruction of the body. The serum electrophoresis showed the IgG level of 2,760 milligrams per cent, IgA 32 milligrams per cent, and IgM 25 milligrams per cent. The sedimentation rate was 57 millimeters per hour, hemoglobin 10 grams per cent, white blood count 6,820, platelet count 389,000. The BUN, serum calcium, creatinine, and other chemistries were normal.

Treatment

The patient was placed on chemotherapy consisting of melphalan (Alkeran) and prednisone. Three weeks later he was readmitted with back pain, lethargy, constipation, and weakness. The BUN had increased to 33 milligrams per cent, the creatinine 4 milligrams, uric acid 8.7 milligrams, calcium 11.8 milligrams, and phosphorus 5.2 milligrams. The Bence Jones protein was negative. The urine culture grew *E. coli,* 100,000 organisms per cubic centimeter. The hemoglobin was 4.9 grams per cent, white blood count 8,250, and the platelet count 187,000. The patient was treated with blood transfusions and antibiotics for his urinary tract infection.

On his next admission in January, 1969, he continued to have anemia of 9.6 grams, hematocrit 26, white blood count of 3,400, and platelet count of 148,000. The chemistries were normal. The bone marrow showed 11 per cent plasma cells, the IgG was 2,000 milligrams, IgA 25 milligrams, and IgM 19 milligrams. The bone survey showed lytic areas in both humeri, both scapulae, throughout the skull, pelvis, and femurs, compression of the third cervical vertebrae, T-7, and T-12. He continued to take Alkeran.

Did Well On Alkeran

The patient did well on Alkeran, with normal CBC, platelet count, chemistries, normal levels of immunoglobulins, and no bone marrow infiltration with plasma cells until February, 1975. At that time his hemoglobin was 12.9 grams; hematocrit, 36; white blood count, 9,300; platelet count, 155,000; and total protein, 7.5 with

albumin of 4.1. The protein electrophoresis showed a spike typical of multiple myeloma, and the bone marrow contained 23 per cent plasma cells.

In May of 1976 the patient was placed on cyclophosphamide (Cytoxan).

During his last admission in April, 1977, his bone marrow showed 45 per cent plasma cells; hemoglobin, 9.4 grams; hematocrit, 30.3; and platelet count, 202,000. The immunoglobulins showed IgG 2,400, IgA 25, and IgM 18 milligrams. Protein electrophoresis showed a spike in the gamma region.

Another Remission Sought

At the time of this report, the patient is in a chemotherapeutic program consisting of Adriamycin and Cytoxan intravenously every four weeks, plus large doses of prednisone the first seven days of each cycle. With this regimen we hope to induce another remission in this patient. He continues to be active and practically symptom-free.

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A short abstract summarizing the manuscript should be included. This should be typed in double space on a separate page.

Authors are requested to submit a carbon copy with the original.

Illustrations should be numbered and their approximate locations shown in the text. Each should be identified by placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for reproduction should be done in black (India) ink on pure white. Photographs should be on glossy paper and minimum of about 5 by 7 in. in size. A legend should be provided for each illustration and, preferably, attached to it.

All scientific material appearing in *The Journal* is reviewed by the Editorial Board. Manuscripts should be mailed to The Editor, West Virginia Medical Journal, Box 1031, Charleston, W. Va. 25324.

Renal Adenocarcinoma Complicated By Clostridium Perfringens (Gas Gangrene) Myocarditis

ANNE D. HOOPER, M. D.
Chairman, Division of Pathology, Beckley Appalachian Regional Hospital, Beckley, West Virginia.

An elderly patient with a healed myocardial infarct and diabetes mellitus, incapacitated by recurrent renal adenocarcinoma, developed huge decubitus ulcers on her hips which became infected by Clostridium perfringens. This led to clostridial septicemia, colonization of the myocardium by Clostridia and rupture of the left ventricle at the site of the old infarct. Generally, this organism causes a rapidly spreading local reaction known as gas gangrene. Rarely, especially in patients with malignancy, it can cause a rapidly fatal septicemia, but it almost never colonizes internal organs. A search of the world literature failed to locate any similar cases of antemortem myocarditis by Clostridium perfringens.

Gas gangrene is caused by one of several Clostridia: perfringens (welchii), novyi (oedematiens) or septicum (vibrion septique). These organisms are ubiquitous in nature, being found in soil and normal gastrointestinal tract. They can survive and grow only where the oxygen tension is extremely low, and hence gas gangrene is rare. It usually occurs in large, necrotic, soil-contaminated wounds. Necrotic tissue has a very low oxygen tension, so the organisms multiply rapidly, producing a vast amount of carbon dioxide and a number of potent enzymes and toxins which diffuse rapidly into adjacent tissue, destroying it and making a suitable environment for further spread of the organisms.

Systemic clostridial infections are extremely rare, the most common being a rapidly fatal septicemia. We recently had a case of Clostridium perfringens septicemia with acute clostridial myocarditis and rupture of the left ventricle. Search of the literature failed to reveal any similar cases.

Case Report

This 67-year-old white female was admitted to the Beckley Appalachian Regional Hospital July 27, 1976, complaining of fever and debilitation.

In 1967, she had "kidney stones" which responded to medical treatment. In 1970, she developed hematuria from a left renal adenocarcinoma which was removed at surgery. Preoperatively, the blood pressure was 140/70 mm. Hg. and the heart was enlarged by x-ray. The postprandial blood sugar was 138 mg. per cent; cholesterol 518 mg. per cent.

In 1972, a small recurrent renal adenocarcinoma was excised from the nephrectomy scar. Skeletal survey and chest x-ray showed no metastases. A diffuse precordial systolic murmur was noted. A year later a larger recurrent mass in the same area was excised, following which she received 5000 rads to her left flank. For several years her blood sugar and cholesterol levels had been suggestive of mild maturity onset diabetes, but no treatment for diabetes had been given. Five months after receiving left flank radiation, she was admitted with severe ketoacidosis, the glucose being 1260 mg. per cent and pH 7.02. She was placed on 25 U NPH insulin thereafter and needed insulin the rest of her life. She was seen twice thereafter in the emergency room with hypoglycemic reactions. She had intermittent atrial fibrillation and her chest x-ray showed an enlarged heart with a calcified aortic valve.

In June, 1975, she was seen at a different medical center for severe left leg pain. Four thousand rads were given to the left flank with relief of pain and recovery of function. In November, 1975, she became bedfast due to pain in her lower back and both lower extremities. She recorded a weight loss of 40 pounds in the past two years. In January, 1976, she was admitted with the following physical findings: nodule in the right thyroid lobe, a high-pitched pansystolic murmur over the entire precordium, fine crackling rales, radiation hyperpigmentation of the back, slight dependent edema, tenderness of the lower lumbar regions, and weakness and atrophy of her lower extremities. Further radiotherapy could not be tolerated; function of her lower extremities could not be restored due to partial replacement of the lumbar vertebrae by tumor; and bilateral cordotomy for pain relief at the level of D2 and D3 was done. Postoperatively, she had analgesia from D6 down. She no longer complained of pain, but became lethargic and somnolent.

Decubitus Ulcers Of Hips

At home she was bedridden, paralyzed from the waist down, incontinent of stool and urine,

and complained of pain in her lower extremities. She developed large decubitus ulcers of her hips.

She was readmitted to the Beckley Appalachian Regional Hospital May 19, 1976, with a one-week history of fever. Her temperature was 103°F., respirations 24, pulse 88, BP 178/100 mm Hg. She was obtunded, responding only to pain. A systolic ejection murmur was present. She had large decubitus ulcers of her hips. Urinalysis showed + albuminuria, 3+ glycosuria, trace acetone, 15-20 WBC/HPF, 15-55 RBC/HPF, 1-3 hyaline casts/LPF, and many bacteria (Pseudomonas aeruginosa). The glucose was 504 mg. per cent, BUN 65 mg. per cent, CO2 content 22 meq/l, hemoglobin 11.5 gm. per cent, WBC 5200/mm.^{3} Differential: 89 per cent segs, 9 per cent lymphs, 2 per cent monocytes. The calcium was 14 mg. per cent, phosphorus 2.9 mg. per cent. The chest x-ray showed three small densities, one of which had been present on previous examinations. The EKG showed nonspecific ST abnormalities. She was treated with insulin, cephalothin sodium (Keflin) and disodium carbenicillin (Geopen) systemically. Oxygen and Granulex powder (consisting of trypsin, balsam Peru and castor oil) were used locally on the decubiti. Her diabetes proved difficult to control. She was transferred to a nursing home July 8, 1976.

Her final admission was July 27, 1976. No interval history is available. Her temperature was 101°F.; pulse, 84; and blood pressure, 110/80 mm. Hg. This was a conscious, cooperative, debilitated, cachectic, lethargic, pale woman. Positive findings were: occasional scattered crepitations of the lungs with decreased air entry, especially on the right. A grade II systolic ejection murmur was heard all over the precordium. Fecal impaction was present. On both hips and on the right foot were large decubitus ulcers. The hemoglobin was 9.4 gm. per cent, hematocrit 28 per cent, WBC 6000/mm^3 with 71 per cent segs, 21 per cent stabs, 7 per cent lymphs, and 1 per cent monos. There was slight polychromasia, moderate anisocytosis, a few target cells, and Döhle inclusion bodies. The debubiti were given nitrate soaks. No antibiotics were given. On July 26, "severe, brown, foul smelling drainage" was noted to be "seeping from wounds." She was hallucinating: she saw bugs and she thought the bed button was a little boy. She was given pentazocine hydrochloride (Talwin) for pain. On July 29, it was again noted that there was a foul-smelling drainage from her decubiti. Her urine consistently showed 4+ sugar. Her temperature ranged from 98°F. to 101°F. Her urinary output was adequate. At 3:00 a.m. on August 1, 1976, she was pale with an irregular pulse of 100 and had slightly labored breathing. She died quietly at 4:30 a.m.

Autopsy

Gross: The autopsy was performed six hours after death, the body having been kept in the morgue refrigerator from shortly after death until the autopsy was performed. No evidence of decomposition was evident either externally or internally. There was marked emaciation, contractures of the lower extremities, slight jaundice, and large deep decubitus ulcers on both hips and right foot (Figure 1). The skin surrounding the decubiti and the depth of the ulcers were stained brown. As the tissues were cut, gas could be heard to escape, and bubbles could be seen in the smaller blood vessels.

The pericardial sac was distended with gas like a balloon. It also contained 150 ml. of clotted blood. There was a softened, mushy area in the lateral wall of the left ventricle which was the site of rupture (Figure 2). Some patchy myocardial fibrosis was present in this area. There was marked calcific aortic stenosis (Figure 3). There was marked arteriosclerosis of the left circumflex coronary artery and the aorta. A culture from the heart blood yielded Clostridium perfringens, group D enterococci and Proteus mirabilis.

The left lung contained two nodules less than one cm. in maximum dimension and the right lung one similar nodule. There was a firm, unencapsulated 8 x 6 x 6 cm. mass in the left kidney bed which was firmly attached to the aorta and vertebral column. There was a nodular goiter. The brain was not examined; however, a portion of the thoracic and lumbar cord was grossly normal.

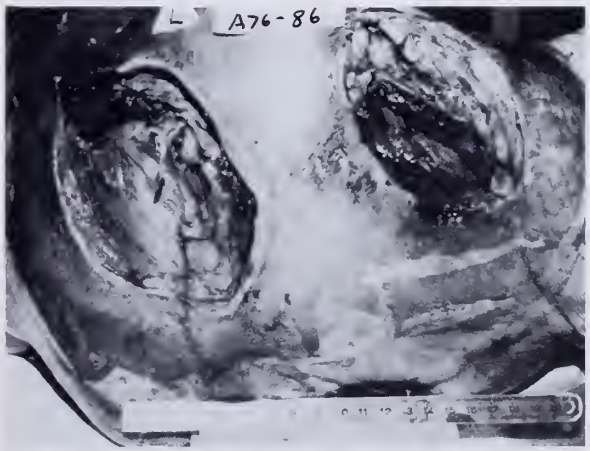

Figure 1. Decubitus ulcers of left hip.

Figure 2. Heart. Probe is through area of perforation. In this area the myocardium was so mushy it collapsed in contrast to normal consistency of other areas.

Microscopic: Sections taken from multiple areas of the left ventricle contained foci of neutrophilic infiltration. Most myocardial fibers were normal, but some had lost their nuclei and were smudgy (Figure 4). Occasional nuclei were pyknotic. These lesions were scattered throughout the myocardium with the greatest concentration in the area of mushy softening and perforation. In the same area was evidence of an old infarct (patchy fibrosis) (Figure 5). In addition, venous walls, endocardium, subepicardial fat and epicardium were involved. Numerous Clostridia could be seen interstitially in conjunction with neutrophils. No gas formation was visible in areas of vital reaction. Pockets of gas and clumps of Clostridia were present in many internal organs, but no other organs showed a vital reaction to these organisms.

Two of the lung nodules were metastatic renal adenocarcinoma (Figure 6). One was an old calcified fibrotic nodule. There were no other metastases. The left kidney bed mass was recurrent renal adenocarcinoma with necrotic and fibrotic areas.

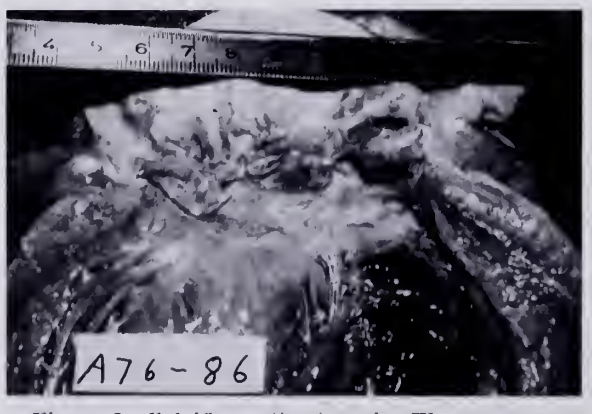

Figure 3. Calcific aortic stenosis. The cusps were so rigid that the lumen would scarcely admit the tip of a finger before cutting the valve ring.

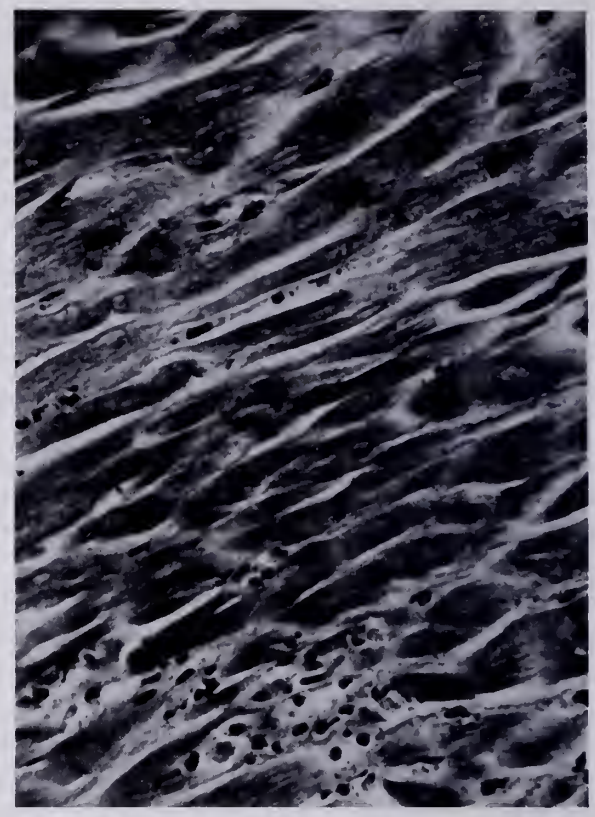

Figure 4. Posterior papillary muscle H & E. 400X. Normal myocardial nuclei at the top. Beneath is an area of myonecrosis without visible nuclei. Below is interstitial neutrophilic infiltration.

The pancreas showed extensive fibrosis replacing much of the acinar and islet tissue. There was no hyalinization of the islets or postmortem autolysis (Figure 7). The thyroid showed adenomatous goiter. The remaining kidney showed early changes of Kimmelstiel-Wilson disease (intercapillary glomerulosclerosis) and arteriosclerosis. The spinal cord showed demyelinization of the posterior and lateral funiculi.

Discussion

The patient's problems were primarily due to renal adenocarcinoma, diabetes and arteriosclerosis. Her metastases were too small to be significant clinically. The recurrent mass was relatively small, but by invading the vertebral column it had incapacitated her. Prior to her flank irradiation, her blood sugars and cholesterol suggested mild, maturity onset diabetes. Five months after flank irradiation she developed severe diabetic ketoacidosis and needed insulin from then on. The timing and the finding of marked fibrosis of the pancreas makes it highly probable that the irradiation to the flank dam-

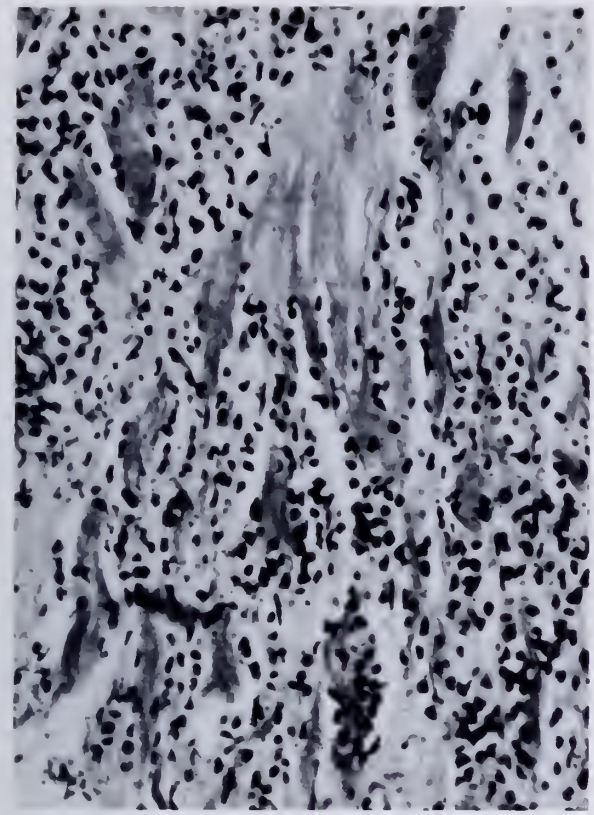

Figure 5. Heart. area of perforation. H & E. 400X. Dense infiltration by neutrophils and almost complete destruction of myocardial fibers.

aged the pancreas sufficiently to convert a mild, maturity onset diabetes into a severe, insulin-dependent diabetes. She had not had diabetes long enough for full blown Kimmelstiel-Wilson disease to develop.

Infection of the decubiti by Clostridium perfringens must have occurred, for the description of "severe, brown, foul smelling drainage" described on the chart well matches "profuse, serosanguineous, slightly foul smelling fluid" described by Robbins.[1] There was no debridement of the ulcers, nor were any oxidizing agents used on the ulcers during the final admission. The presence of diabetes enhanced the probability of developing severe infection in the decubiti and septicemia. The growth of Clostridium perfringens is enhanced by calcium: her serum calcium was 14 mg. per cent. Gorbach reports 29 cases of clostridial septicemia. Decubitus ulcers were the source in four cases.[2] While in healthy people clostridial infections rarely develop except after contaminated injuries,[3] including surgery,[4] it is not uncommon to have clostridial infections including gas gangrene and septicemia in the absence of trauma in patients with malignancies.[5,6] Clostridia are normal inhabitants of the gastrointestinal tract, and presumably the source of

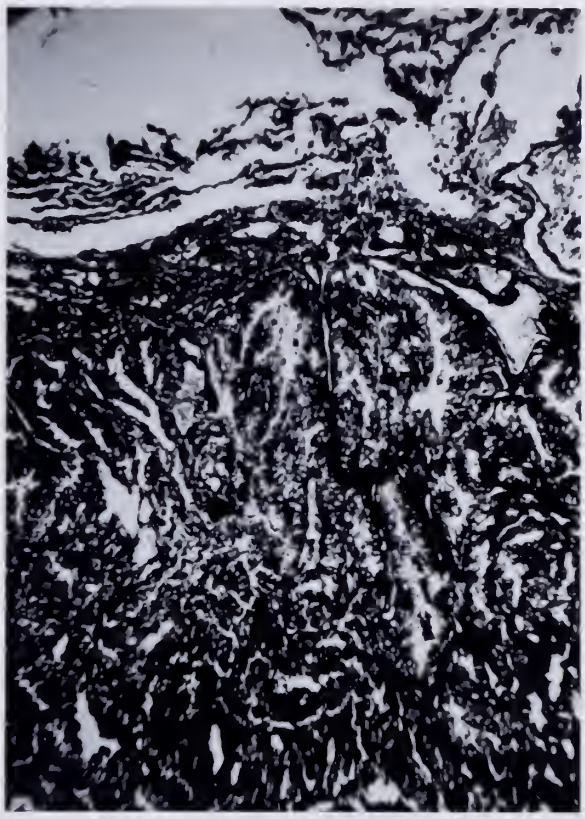

Figure 6. Lung metastasis. H & E. 100X.

septicemia in many of these cases. Clostridia migrating out of the gastrointestinal tract are the source of the gas which causes bloating of decomposing bodies.

Rapid Downhill Course

When septicemia does develop, there is a rapid downhill course with death in 24 to 48 hours. Characteristic of septicemia is a relatively rapid pulse for the temperature, and shock. Dyspnea occurs in about 50 per cent of patients. Jaundice, which is secondary to hemolysis caused by Clostridia, occurs in about 25 per cent of

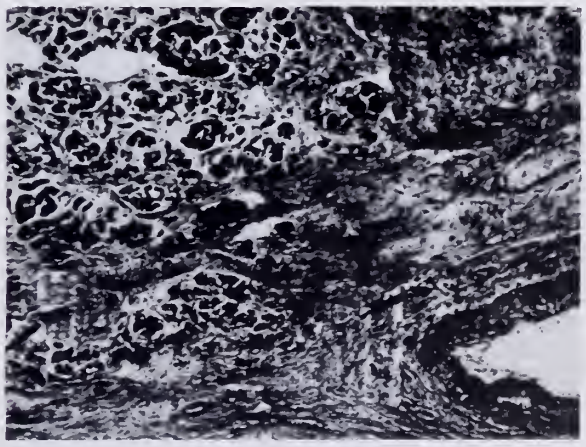

Figure 7. Fibrosis of pancreas. H & E. 100X.

patients.[5] Generally, there is no antemortem colonization of tissue outside the site of injury; however Case *et al* describe a case of endocarditis due to Clostridium perfringens.[7]

This patient had myocardial anoxia due to severe coronary arteriosclerosis, high serum calcium, malignancy, and diabetes mellitus. Undoubtedly, the most anoxic area was that of the old infarct, explaining why the area of greatest vital reaction, dense neutrophilic infiltrate and myonecrosis with perforation, are superimposed upon the old infarct. Other areas of the myocardium show similar, but less advanced reaction.

The description of the changes in skeletal muscle[1] are extremely similar to those found in the myocardium in this case, with myonecrosis causing "semi-fluid" muscle and a sparse neutrophilic infiltrate. Areas of myocardial infarction show some softening, but are not nearly as soft and mushy as clostridial myonecrosis which caused the edges of the perforation to collapse and come together, making the perforation invisible in Figure 2.

The gross pictures and microscopic slides were shown to a number of pathologists who concurred in the diagnosis of Clostridium perfringens myocarditis with rupture. There was variation of opinion as to whether the rupture was pre- or post-mortem. Rupture would have caused death and explains the presence of clotted blood in the pericardial sac. If the rupture had occurred within a short period after death the same findings would be present, although in the author's opinion there would have been less blood in the pericardial sac. The clostridial septicemia alone could have caused death.

Drugs Mentioned

Cephalothin sodium (Keflin)

Disodium carbenicillin (Geopen)

Trypsin, balsam Peru, castor oil (Granulex powder)

Pentazocine hydrochloride (Talwin)

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You can do very little with faith, but you can do nothing without it.

—Samuel Butler

Hypnosis, A Method: A 'Cookbook' Methodology

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There are many books and papers on hypnosis, its efficacy, usefulness, theories about what happens, the history, its safety or danger. This article, which can simply be torn out of the Journal, brings a method to the physician. With further data on multiple trials in many situations, the fear and mystery surrounding this technique should dispel like morning fog; and then we can all begin to come to grips with multiple uses of this tool which can be in every physician's armamentarium.

HYPNOSIS has been the "shady lady" of medicine for many years, sporadically waxing and waning in popularity. The methods are varied, but in principle are very similar. This article is to fulfill a need for a "cookbook" type of lullaby that will work with susceptible subjects. That is, if the indented portions of this manuscript are simply read to a person, susceptible people will go into a light, mild, moderate or deep trance simply as a response to the reading.

It is my concern that hypnosis should be available to well trained individuals who will be responsible for their patients throughout their contacts with them. I felt that physicians as a group need some concrete methodology to begin to utilize this fascinating tool for the health and welfare of their patients.

It is also the purpose of this paper to remove from this "art" the "blackness and mystery" that has been linked to it, ascribing almost magical powers to the "practitioners of the art."

Many uses of hypnosis will be discovered when a greater number of responsible and trained practitioners are utilizing this technique.

I, like Freud, found hypnosis to be less useful than I had hoped—when I was first introduced to it. Two examples of successful uses of hypnosis follow:

Case Report One

A simple example of the use of hypnosis involves the case of a ten-year-old boy who fell from the back of a station wagon and was dragged on gravel for several blocks before being discovered. His entire back required debridement and grafting. His itching and scratching, even in his sleep, caused exacerbation of inflammation and infection. Restraints somehow never worked. I was called in to consult and used hypnosis to suggest that the "itch" would go away entirely and that he would have no need to scratch. After two sessions he turned the corner and was healing and sleeping through the night.

Case Report Two

Another example involved getting at unconscious dream material in a young adolescent whom I treated for depression and psoriasis. Her conscious associations to the dreams were bleak and short. Under hypnosis she revealed a tremendous hostility toward her mother and a wise insight into her parents' impending divorce. She had never cried in her life! When she was given permission to cry her mother became extremely anxious and slapped her. She cried for 24 hours. Following this crisis (KAIROS), the patient learned not to turn her hostility upon herself and scratch herself (possibly resulting in an allergic response to her own detritus). Her mother's therapy and ability to accept was enhanced with therapy, and the patient's skin lesions began to heal for the first time in seven years. With her, the accessibility of repressed affect and much other material was the key to understanding the "dynamics" at home and the beginning of a "cure."

Methodology

The visual fixation method is one of the oldest and most effective techniques of hypnosis. The wording is for use with the *spot.* Any object such as a light (flickering or fixed), a ring, or a spiral can be used. In that case, substitute the name of your fixation object for the word "spot."

Read the following monotonously. Make no effort to read in an "interesting" or dramatic fashion. Make your voice as level as a metronome. Weight each syllable equally. This is a "lullaby." The presence in the following of a dash (—) indicates a pause.

> 1. Relax comfortably in your seat — Please place your feet flat on the floor — Move back firmly against the back of the chair — Unclasp your hands and let them lie loosely on your thighs — Relax your hands and arms.

Observe the manner in which the subject does what you ask. You are already getting a response to suggestion. Make sure you are under-

stood. If the subject understands, but does not do as you ask, do not waste your time. The subject is resisting, consciously or unconsciously.

2. The *spot* at which you are looking is simply an object upon which you can closely fix your attention. Please fix your attention upon it. — While you are looking at it you will not be distracted by other things. Keep your attention firmly fixed on it. As you watch it you will find your eyes getting slightly out of focus. Make no attempt to see clearly or see details. Just watch the spot. — Watch the center of it. — Don't pay much attention to me.

3. Please be assured that nothing will be done that will in any way embarrass you or cause you any discomfort. Quite the contrary, if you have the ability to closely focus your attention and to accept in a passive manner the suggestions that I am reading to you, the following experience will be one of the most refreshing and delightful of your whole life.

4. As you watch the *spot* you will notice that your eyes will become drowsy, drowsy, and sleepy, very sleepy. Soon they will close of their own accord as your body relaxes more and more.

If the subject's eyes close before they are TOLD to close, finish the paragraph that you are reading and skip immediately to paragraph 16.

5. Your ability to be hypnotized has absolutely nothing to do with your intelligence or your strength of will. It depends entirely on your ability to focus your attention closely and to keep it focused without wandering. You are finding it easy to do this with the aid of the *spot.*

6. Let us now relax every muscle in the body. — Relax the toes on your right foot. Let them go limp, limp, heavy and relaxed. Let this relaxation creep up through the ball — and the arch of the feet — up to the ankle — so that your right foot is completely relaxed, relaxed and heavy, heavy and limp.

7. Now relax the toes on the left foot, the toes, the ball, the arch and the heel. Your left foot is completely relaxed, relaxed and limp, limp and heavy. Both feet are now completely relaxed, completely relaxed, relaxed and heavy.

8. Let this heaviness creep up the calf of your right leg — so that you are now completely relaxed from the tips of your right toes to the knee. Now let the left calf relax in the same manner so that both feet and legs are completely relaxed up to the knees.

9. Let the relaxation extend up through the large muscles of the right thigh so that your right leg is completely relaxed to the hip. Now let the left thigh also relax so that your feet and legs are heavy, heavy and relaxed, heavy and relaxed, relaxed and limp: so relaxed, so limp, so heavy.

10. Your eyes are very, very heavy now, so drowsy and so sleepy. It is becoming difficult for you to keep your eyes open. Soon they will close of their own accord. Soon your eyes will close of their own accord. They are becoming so drowsy and sleeply with the watching — watching — watching.

11. Now relax the fingers of the right hand. Feel them getting limp and heavy and relaxed. Feel the whole right hand relaxing more and more, getting more and more limp, more and more heavy. Now relax the fingers of the left hand, letting go completely, all the muscles relaxing: the fingers getting heavy, limp, relaxed, the whole left hand becoming relaxed and heavy. Now let that feeling flow up the arms, the right forearm relaxed, the left forearm relaxed, the right upper arm relaxed, the left upper arm relaxed, both arms, both hands relaxed and heavy, relaxed and heavy and limp, right up to the shoulders. By this time you undoubtedly notice a slight pleasant tingling in the toes and fingers. This feeling will increase until the whole body is bathed in a pleasant glow of utter relaxation.

12. Now we are going to relax the torso. The hips, the large back muscles, the abdomen, the chest muscles and the shoulders will all relax at once. We are going to take three deep breaths. As we exhale each one we will notice the torso relaxing more and more and with the third deep breath will come a complete and utter relaxation of the entire body. Now breathe slowly in — in — in, a full deep breath. Out! Relax completely. Now a deeper breath in — in — in — in. Out and completely relaxed. Now you are breathing slowly, gently, deeply as a sleeper breathes. Every muscle in your chest, shoulders, back, abdomen and hips is completely relaxed and your whole body is heavy, heavy, heavy and limp.

13. You are now completely relaxed in your limbs and in your body. Your eyes are so sleepy, so drowsy. The lids are so heavy. All the muscles in your neck are now beginning to relax. Your head feels so heavy as the muscles release their tension. Let your jaw muscles relax so your teeth do not quite touch. Jaw muscles completely relaxed. Let all the muscles of the face and scalp relax completely. So limp, so heavy, relax completely.

14. Now we are going to relax the eye muscles. Listen closely, I am going to count to 21. On the first count, close your eyes. On the second count, open them with your attention still fixed on the *spot*. On the third count, close them and on the fourth count, open them. Continue in this manner. Each time your eyes open have your attention fixed closely on the *spot*. You will find that each time you close your eyes they will tend to stay closed. Each time that you open them it will be more difficult to do so, more difficult than the last time, much more difficult. Before the count of 21 is reached, your eyelids will stick so tightly closed that it will be impossible to open them, quite impossible to open them.

15. Here we go, one, closed, two, open, three, closed and heavy, four open, five closed and so sleepy, six, so sleepy and drowsy, seven. so very sleepy, eight sleepy and peaceful, peaceful and relaxed, nine, so sleepy, so sleepy, so sleepy, 10, so completely and utterly relaxed, feeling so peaceful and calm, so free from tension, 11, drowsy and peaceful, 12, sleepy, so sleepy, 13, completely relaxed, every muscle free from tension, 14, so sleepy, so sleepy, so sleepy, 15, sound asleep, sound asleep, sound asleep, 16, fast asleep, fast asleep, 17, feeling so good, so perfectly relaxed, so peaceful and restful, 18, peaceful and restful, peaceful and restful, 19, relaxed and calm, relaxed and calm, 20, sound asleep, sound asleep, sound asleep, 21, sound asleep, sound asleep. Let nothing disturb you or awaken you. Let nothing disturb you or awaken you.

If the subject's eyes have closed previous to the count of 21, start reading paragraph 16 immediately after the eye closure. If the subject opened his eyes on the count of 20, caution him, "Just let your eyes stay closed and relax more and more, more and more."

16. You are sound asleep — sound asleep. You are perfectly relaxed. So peaceful and calm. So relaxed, so peaceful. Relaxing more and more, going deeper and deeper, and deeper to sleep. Deeper and deeper and deeper to sleep. Deeper and deeper, deeper and deeper. Relaxing more and more. Every muscle in your body relaxed, so relaxed, so peaceful, so comfortable. Let nothing disturb you or awaken you. When you do awaken you will want the suggestions that will make this the most wonderful experience of your life, so until that time nothing can or will disturb you or awaken you from your deep, sound, restful sleep.

Tests for Depth of Hypnosis

Read more briskly, with emphasis, in a business-like manner. Be firm without dominating. When a word is CAPITALIZED emphasize it forcefully.

17. You are now about to have the opportunity to experience the power of your own unconscious mind. We are about to test your ability to accept a suggestion, to make it your own and to implant it in your unconscious mind so firmly that even if you later try to consciously oppose the suggestion you find yourself completely unable to do so. I am going to describe each suggestion or test before asking you to accept it. You may refuse any suggestion at your pleasure, but if you accept a suggestion you will find yourself completely responsive to it. You may indicate your acceptance of a suggestion by nodding your head. You can nod your head easily and without awakening. Do you understand me clearly? If so, please nod your head.

Wait for an acknowledgment. If the head is nodded, proceed. If the head is shaken repeat the entire preceding paragraph and if the head is not nodded at the end of the second reading, go through it again, sentence by sentence. Ask for a nod to indicate understanding at the end of each sentence. When you find the point of misunderstanding, discuss this point "ad lib" until you do get a nod of understanding.

18. If for any reason you do not wish to accept a suggestion, shake your head. Do you understand?

Wait for acknowledgement.

Test One: Eye Catalepsy

19. That's fine. Our first test will be to lock your eyelids so tightly closed that no

conscious effort that you can make will open them. Are you willing to do this?

Wait for acknowledgement.

20. Very well, your eyelids are very, very heavy. They are sticking tightly closed, tightly closed. Sticking tighter and tighter, AND TIGHTER. THEY ARE GLUED TOGETHER. YOUR EYELIDS ARE GLUED TOGETHER. THEY ARE STICKING SO TIGHT THAT NO MATTER HOW HARD YOU TRY TO OPEN THEM THEY CANNOT BE OPENED. THEY SIMPLY STICK TOGETHER, AND TIGHTER, AND TIGHTER. Try to open them: IT'S ABSOLUTELY IMPOSSIBLE. THEY WILL NOT OPEN. Go ahead and try: THEY WILL NOT OPEN.

Watch the subject's eyes closely. If the subject succeeds in forcing his eyes open, he is not quite deep enough for this test. Without showing any dismay, say to him,

All right, you were not quite deep enough for this one, but you soon will be.

Return to paragraph 13 and continue straight through eye catalepsy again. If he has made a futile attempt, or after a five-second wait during which no attempt is made, continue.

21. All right, don't try any more. Relax completely. Your eyes are no longer locked tight together, but please do not open them. You can open them easily when I ask you to awaken, but leave them closed for the present. Relax completely and go deeper and deeper to sleep, deeper and deeper to sleep, deeper and deeper to sleep.

Test Two: Heavy Arm Catalepsy

22. Our next test will be to make your right (or left) arm so heavy that conscious effort cannot lift it. If you wish to do this, please nod your head.

Wait for acknowledgement. If the subject shakes his head, indicating a refusal of any particular suggestion, say,

"Very well, we will pass this one," and pass to the next test.

IMPORTANT: If at any time during the hypnosis, the subject awakens spontaneously, do not fail to say "WAKE UP, YOU ARE WIDE AWAKE." This is necessary even though the subject is obviously awake.

23. That is fine, now relax more and more, every muscle in your body completely relaxed. Your right arm especially relaxed, relaxed and heavy, heavy and relaxed. Every fiber of every muscle in your right hand, your right arm, and your right shoulder completely relaxed. Every fiber of every muscle relaxed. That makes your arm feel very heavy, very heavy.

Subject's hands are resting loosely on the thighs. Gently push the relaxed arm to the outside so that it will slip off the thigh, and if seated in an armless chair, hang straight down. In an arm chair it will slip down to the cushion.

24. You will notice how heavy it feels and it is getting heavier and heavier, MUCH TOO HEAVY TO LIFT. YOUR ARM IS GETTING HEAVIER AND HEAVIER. IT IS SO HEAVY THAT IT IS ABSOLUTELY IMPOSSIBLE FOR YOU TO LIFT IT. IT IS MUCH TOO HEAVY TO LIFT, MUCH TOO HEAVY. IT FEELS AS THOUGH IT WERE MADE OF SOLID LEAD, SOLID LEAD, FAR TOO HEAVY TO LIFT. Try to lift it. IT IS MUCH TOO HEAVY TO LIFT. Try to lift it. IT IS FAR TOO HEAVY TO LIFT.

Wait a few seconds. If the arm lifts an inch or so, and the struggle to lift it is apparent, but unsuccessful, ignore it. If the arm lifts six or eight inches and is held there, say,

IT IS GETTING HEAVIER AND HEAVIER, THE WEIGHT IS DRAGGING IT DOWN, DOWN, DOWN, DOWN.

Repeat this over and over until the arm drops or the subject awakens.

25. You see, at this time your unconscious mind is far more powerful than any conscious effort you can make. If you accept a suggestion it is completely effective. Now your arm is getting lighter and lighter. Now it is completely normal, relaxed, but no longer heavy. You may move it easily if you wish to. Will you please put it back in your lap? It moves easily now.

Observe the ease with which the subject returns the hand to the lap. This is important! Be sure that all suggestion of heaviness is eliminated. Observe this precaution *every* time you make a suggestion which is *not* intended to be carried over into the waking state.

Test Three: Rigid Arm Catalepsy

26. Our next test will be to make your left (or right) arm so rigid that your conscious effort cannot bend it. If you wish to do this, please lift your left arm, extend it

straight out from the shoulder, and extend the fingers.

Wait for the subject to indicate his acceptance by extending his arm. If he extends it with the elbow bent, ask him to straighten it. If he does not extend it ask him to express his understanding of the suggestion by nodding his head. If he understands it, but does not wish to do it, ask him to express his refusal by shaking his head, then pass to the next suggestion.

27. That is just right. Now you notice all the muscles in your left arm beginning to get tense and rigid. You can feel the muscles tightening up — tightening up — tighter and tighter. You can feel your whole arm getting rigid — rigid — rigid — stiff and unyielding — rigid as a bar of steel. YOUR ARM IS NOW SO RIGID THAT IT IS ABSOLUTELY IMPOSSIBLE FOR YOU TO BEND IT. IT IS AS RIGID AS A STEEL BAR. IT CANNOT BE BENT. Try to bend it. IT WILL NOT BEND. Try to bend it. IT IS JUST AS RIGID AS STEEL.

Wait a few seconds, if the subject is having some success in bending it, keep saying,

"RIGID, RIGID AS STEEL, STIFF AND RIGID."

From this point on, if any particular test fails dismiss it casually with the remark,

"Oh, well, you didn't make the grade on this one, but you will on the next, so don't let it disturb you."

Do not be afraid to challenge strongly on any test. A test is effective only if both you and the subject are satisfied that a definite response is obtained. Remember that a failure is *not* a failure on your part, but a failure on the part of the subject. Practice can make a good subject out of a poor one.

28. You see, it will not bend. Now the muscles are relaxing, the tension is leaving the arm. Now you can bend it, it feels fine, marvelous. You may put your hand in your lap; will you please?

Test Four: Hand Levitation

29. So far we have been demonstrating how your unconscious mind can prevent you from consciously doing things. Now we can demonstrate the power of the unconscious mind to do something without any conscious effort on your part. This test will be to have your hand lift from your lap without any effort on your part. If you would like to do it, nod your head.

Wait for acknowledgement.

30. First of all we want to know consciously and unconsciously which muscles are used in raising your hand to your shoulder, so will you please bend your right elbow and raise your right hand — touch the shoulder — that's right. Now put your hand back in your lap — you now know consciously and unconsciously which muscles are used in this operation. Will you please do it again — that's right. Now put it back in your lap — and for the last time bring your hand up to your shoulder — and put it in your lap.

31. Now make absolutely no conscious effort to raise your hand. We are going to turn that job over to your unconscious mind. Leave your arm as relaxed as the other one which has not moved. You will be interested in what happens. The same muscles that tightened up a few seconds ago are again beginning to contract. The muscles are contracting and lifting your hand up — up — up. The feeling will be strange. Your hand will seem to get lighter and lighter and finally to float up of its own accord. Your hand is coming up — up — up — up — up -- up — up — up — up — up — up — up — up — up — up. Your hand is getting lighter and lighter, lighter and lighter, coming up.

This test usually takes several minutes. In some cases 15 or 20 minutes. Continue alternating the last two statements of the above suggestion. If after 10 minutes the hand has not moved noticeably, gently place your hand under the wrist and lift the hand up two or three inches so that it is free of all support. Then say,

You don't seem to have quite enough power to get started. Just hold your hand there. Don't make any effort to lift it or resist, just hold it there. Up — up — up etc., lighter and lighter, etc.

In 10 minutes more the hand will have raised noticeably or the subject will have relaxed the arm and dropped it to the original position. In the latter case abandon this test. If there has been a definite and noticeable motion, but you do not wish to take the time to finish, lift the subject's hand to touch his shoulder.

32. Up — up — up — up — up — higher and higher, higher and higher, your hand is moving toward your shoulder now.

Now it is touching your shoulder — your arm is relaxing — it feels fine, wonderful, perfect in every way. You may move it as you wish.

Test Five: Automatic Motion

33. Now we can demonstrate how the unconscious mind can keep you doing something even against your conscious effort to stop. Would you like to see how this works? If you would, just nod your head.

Wait for the acknowledgement.

34. That's fine. Do you write with your right or left hand? Please raise the hand that you write with up in front of you. Now just imagine that you are back in school standing at the blackboard with chalk in your hand. You are about to practice making ovals. You remember the ovals? Round and round. Round and round. That's right. Remember how you used to make them? Round and round, round and round. Now just keep on making the ovals, round and round. So far you are doing this consciously because I asked you to and because you want to, but we are going to turn this action over to your unconscious mind.

35. As you continue to make the ovals round and round, round and round, the action is becoming just as automatic as the beating of your heart. As you know, the action of your heart is not subject to conscious control. Your heart speeds up and slows down in response to the needs of your body in a completely unconscious manner. Thinking about it will not change its action. It is automatic, beyond your conscious control. You cannot stop your heart from beating by thinking about it.

36. In the same way the motion of your hand is now completely automatic. IT IS JUST AS AUTOMATIC AS THE BEATING OF YOUR HEART. IT IS NOW IMPOSSIBLE FOR YOU TO STOP MAKING OVALS. YOUR UNCONSCIOUS MIND IS FORCING YOUR HAND TO GO ROUND AND ROUND, ROUND AND ROUND IN SPITE OF ANY EFFORT THAT YOU MAY MAKE TO STOP IT. Try to stop it. IT WILL NOT STOP. Try hard to stop it. YOUR HAND KEEPS GOING ROUND AND ROUND, ROUND AND ROUND.

Pause for the test. As soon as the subject has made an obvious effort to stop the motion, continue. If the motion slows down, but does not stop, continue saying,

ROUND AND ROUND, ROUND AND ROUND

until the subject stops fighting it. If the subject simply relaxes the arm and stops the motion, the test has failed. Admit it as a failure on the part of the subject and continue.

37. Now the motion is slowing down, slowing down. Now your conscious control has returned. Now your arm is relaxed and you may do with it as you wish. Just relax completely and go deeper and deeper to sleep. Deeper and deeper to sleep. Far deeper than you have been before.

Conditioning for Future Response

The following suggestion will make future hypnosis. on the part of the subject, easier and faster. It also gives the subject reassurance which is invaluable.

38. The next time you wish to be hypnotized you will find it much easier. You will go much deeper, very much faster. NO ONE WILL EVER BE ABLE TO HYPNOTIZE YOU UNLESS YOU GIVE YOUR VERBAL PERMISSION. IN ORDER TO BE HYPNOTIZED IT IS NECESSARY FOR YOU TO EXPRESS VERBALLY YOUR WILLINGNESS TO BE HYPNOTIZED. IF I ASK YOUR PERMISSION TO HYPNOTIZE YOU AND YOU SAY "YES," "O.K.," "SURE" OR ANY OTHER EXPRESSION OF CONSENT, YOU WILL BE HYPNOTIZED DEEPLY AND QUICKLY. IF YOU DO NOT GIVE YOUR CONSENT, IF YOU SAY "NO" OR DO NOT SAY ANYTHING, NO ONE CAN HYPNOTIZE YOU BY ANY METHOD. If you understand, nod your head.

Wait for acknowledgement. If the subject does not understand perfectly, repeat in a conversational tone, asking for a nod of understanding after each sentence. When you find the point of confusion, explain in detail.

39. The next time you wish to be hypnotized by me, we can arrange a signal. We will use a signal with three parts, one part is yours and two parts mine. All three parts are necessary to induce hypnosis in this way. The first part is your permission. WITHOUT YOUR PERMISSION I CAN DO NOTHING. If you give your permission, I will say, "SLEEP." This is the second part. Then I will snap my fingers. That is

the third part. Do you understand? First your permission, second I say "SLEEP," third I snap my fingers. WITH THE SNAP OF MY FINGERS YOUR EYES WILL INSTANTLY CLOSE, YOUR BODY WILL RELAX, YOUR CONSCIOUS MIND WILL RELAX, AND YOU WILL GO INTO A DEEP, DEEP SLEEP, FAR DEEPER THAN YOU ARE NOW. EVERY TIME YOU ARE HYPNOTIZED YOU ARE GOING TO GO DEEPER AND FASTER, BUT NO ONE CAN HYPNOTIZE YOU WITHOUT YOUR PERMISSION.

40. If you wish to be hypnotized, say so. If you say that you wish to be hypnotized I will say "sleep" and snap my fingers. Your eyes will close instantly. Your body will relax instantly. Your mind will relax instantly. You will go deep to sleep instantly.

Test Six: Posthypnotic Handclasp

41. We have demonstrated various ways in which your unconscious mind can affect the activity of your body while in hypnosis. It can also have a very strong effect after you awaken and are not hypnotized at all. For example, it is possible for you to stick your hands so tightly together that even after you awaken it will be absolutely impossible for you to separate them until a signal is given. Would you like to do this one? If you would, extend your hands straight out in front of you — palms facing each other — now interlace your fingers — press the palms tightly together — press the fingers tightly against the backs of the hands.

If the subject fails to follow your lead on this one, ask him to nod his head if he understands. Ask him to shake his head if he does not wish to do it. At this point you can carry on a very casual conversation with the subject without disturbing his trance. If you wish him to speak to you, tell him that he can do so without awakening. If he objects to the posthypnotic suggestion, do not attempt to force it. Remember that although *deeply* hypnotized the subject is still an individual with likes and dislikes.

42. The muscles in your fingers, your hands, your arms are now contracting, forcing your hands tighter and tighter, and tighter and tighter together. Your unconscious mind has taken complete control of your hands and arms. YOUR HANDS ARE STUCK TIGHTLY TOGETHER. THEY ARE STICKING SO TIGHTLY THAT IT IS ABSOLUTELY IMPOSSIBLE TO SEPARATE THEM. NO FORCE ON EARTH CAN SEPARATE THEM UNTIL I TOUCH THEM AFTER YOU AWAKEN. THEY ARE STUCK TIGHTLY TOGETHER NOW AND WILL REMAIN STUCK TIGHTLY TOGETHER AFTER YOU AWAKEN UNTIL I TOUCH THEM. NOTHING CAN SEPARATE THEM UNTIL I TOUCH THEM. After you awaken, when I touch them they will relax, separate and will feel perfect in every way. When I touch them, they will relax and feel perfect in every way. This will occur even though you do not remember what the signal is when you awaken. Your unconscious mind will remember what the signal is when you awaken. Your unconscious mind will remember and your hands will respond even though you have no conscious memory. YOU WILL NOT BE ALARMED OR EXCITED AFTER YOU AWAKEN WHEN YOU FIND THAT YOUR HANDS ARE STUCK TIGHTLY TOGETHER. YOU KNOW IT IS A TEST.

Test Seven: Amnesia

43. One proof of deep hypnosis is the ability to forget what has happened. Of course you know now what has happened, but it is possible for you to forget as you awaken. Just as you may find a dream at night very vivid but forget it entirely as you awaken, you can forget what has happened since your eyes first closed. Would you like to do this? If you would, nod your head.

Wait for acknowledgement. If the subject objects to amnesia, go immediately to the awakening suggestions. Tell the subject,

All right, you will remember everything when you awaken. YOUR MEMORY OF EVERY SENSATION AND TEST WILL BE PERFECT.

If the subject does not object to amnesia, continue with the following:

44. All right. You will notice that your memory is beginning to fade now. Make no effort to remember or to forget. Make no effort at all. The memory is fading, fading, fading. Just as the memory of a dream fades away, so this memory is fading. It is just as though you were on a hill and the fog is rolling in, rolling in, blotting out everything. The fog is getting thicker and thicker, thicker and thicker and you are forgetting, for-

getting, forgetting. The fog is so thick that you cannot see anything. You have forgotten. You have forgotten everything since your eyes first closed. You have completely forgotten, completely forgotten. The fog rolled in so thick that it blotted out everything. The memory is gone, you have forgotten, completely forgotten. The memory is buried deep in your unconscious mind. You have completely forgotten.

Awakening

Become enthusiastic and forceful and dramatic. "Sell" this suggestion as a radio announcer "sells" his commercial. Put pep and vigor into your voice and manner as well as the words you read.

45. When you awaken from this sleep you are going to feel more refreshed and more invigorated than you have ever felt before in your whole life. You will always find hypnosis relaxing, refreshing and invigorating. When you awaken from a hypnotic sleep, you awaken with the physical relaxation of a champion athlete — relaxed with a vigorous, dynamic relaxation that gives you pep, energy and perfect coordination.

46. I am going to count to three. On the count of three your eyes will open. On the count of three you will be wide awake. On the count of three you will be alert, vital, vigorous and perfectly refreshed, refreshed as though you had had a long nap. Here we go now. ONE. You are beginning to wake up now. You feel the life and energy and vigor flowing through your arms, flowing through your legs, flowing through your body. Your eyes feel fresh and clear as though they had been washed with fresh, cold spring water. From head to foot you are feeling perfect, mentally perfect, emotionally perfect. TWO. You are more and more awake, more and more awake, more and more awake. You feel vigorous and energetic, perfect from head to foot. You are completely refreshed, rejuvenated. Your eyes are all ready to open. You are about to wake up. THREE. WIDE AWAKE. WIDE AWAKE. YOU ARE WIDE AWAKE.

Testing for Posthypnotic Response

This can be done quite informally. Ask the subject how he feels. Ask him what he remembers. If he replies that he remembers the whole thing, do not believe him, unless, of course, he rejected the amnesia suggestion. Ask him to tell you what happened. Many subjects confidently state that they know everything that happened, but are unable to state specifically any of the tests in which they have participated. Some will recall a part of what has happened. Some will be able to give you a complete detailed account. In some the memory is completely gone.

Call the subject's attention to the condition of his hands if he has not observed it. Say, "What is this situation?" Ask him to try and separate them. Ask him if he remembers the signal that will release them. If he has no memory, try several false signals such as "standing up," "taking out your handkerchief," "touching his knee or shoulder," etc. After you have made these tests, touch his hands. If they do not relax immediately, tell him,

THAT'S THE SIGNAL, NOW THEY ARE COMPLETELY RELAXED.

IMPORTANT: Even if the subject shows absolutely no posthypnotic effect, give the release signal. Sometimes posthypnotic suggestions which appear ineffective have a delayed reaction.

Note: Bibliography supplied upon request.

111th ANNUAL MEETING

of the

West Virginia State Medical Association

The Greenbrier

AUGUST 23-26, 1978

PLAN NOW TO ATTEND

A message from . . .

The President

A FAREWELL AND A WELCOME

THIS is my farewell contribution to the President's Page. In a way, it's hard to realize that the months have skipped by so rapidly since last September. Further reflection, however, provides recognition that the past year has been one packed with a variety of action—something which always makes time a precious commodity.

Next month, Dr. Robert Hess will be in contact with you here, and I'm happy to welcome him to the "journalistic fraternity." There's no doubt in anyone's mind that he will serve the Medical Association and its members with distinction. His credentials for the Presidency are in the blue ribbon category.

I also know he'll seek, and need, all the support and cooperation each of you can give him. I'm likewise confident that such help will be forthcoming, just as was the case this year.

It has been an honor, as well as a humbling experience, to serve as your President. There'll be a chance to say more about that in the Presidential Address at the Greenbrier later this month.

Once again, I simply want to say a heart-felt, "Thank You." I've never appreciated until this year just how much those two little words really mean.

JOSEPH A. SMITH, M. D., *President*

The West Virginia Medical Journal

Editorials

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author shall be held entirely responsible.

A CONFIDENT OUTLOOK

One thing is certain about the Presidency of the West Virginia State Medical Association. Each year not only is more demanding—but also more sobering. But is West Virginia any different from other states? Basically, not a bit. The problems, the issues, the real concerns about how to maintain and improve effective standards of patient care are the same everywhere. The only variation is in the degree of intensity of a particular problem or issue at a particular time.

Dr. Joseph A. Smith made it clear at the outset of his year as President that if he accomplished nothing else, he would "be himself" every step of the way. Doctor Smith has attained that goal, and much, much more, during an arduous journey calling for tens of thousands of miles of travel into every part of West Virginia as well as elsewhere, some of it in weather that threatened to disrupt completely the best-laid plans and intentions.

He told component society members how he saw things, and how and why he saw them that way. He spoke without notes, and from the heart. He carried into every gathering the dedicated attitude of the hard-working, practicing physician—and he generated the kind of response and respect one in that role of professionalism and perseverance deserves.

West Virginia's physicians, in fact, reacted in a manner which, in Doctor Smith's eyes, made all the sacrifice required of an Association President more than worthwhile. He spoke the truth 100 per cent with a frequent observation that, from virtually every standpoint, he could not have found a more difficult year in which to head the Association.

The last several months have brought to operating levels new health planning, certificate of need and other programs that will have unprecedented impact from the health care standpoint on every man, woman and child in West Virginia. Unfortunately, the public has almost no understanding of this, and one of the more frustrating problems of the times is how to get that particular job of education accomplished.

The emergence of the new programs also has produced growing pains aplenty from other standpoints, with serious doubts as to the logic of the health planning process to date and equally deep concern about adequate and other provider, as well as public, input. The planners insist they have had grass-roots participation from anyone really interested. Still, the early State Health Systems Plan drafts looked like those putting them together were approaching their task like the housewife who might turn to a plumber to ask how many raisins should go into a fruitcake.

Now, Dr. Robert D. Hess moves to center stage, picks up the baton and assumes Associa-

Joseph A. Smith, M. D., President

tion leadership for a new year. Doctor Hess has qualifications and background in impressive measure for his work as President. He knows he'll need all of his solid, determined approach to issues at hand to move effectively in the weeks and months ahead. He also knows that he, too, will need all possible support and understanding from the Association's membership—the physicians on the front line of day-by-day medical care. He must demand that assistance, in fact, and his colleagues must provide it.

State-level legislative and regulatory activities have, in themselves, grown many fold in the past three to four years. Now, equal attention is sought by the American Medical Association and others to issues at the federal levels. State Medical Association leadership and staff have been called upon in increasing measure to deal with health planning, cost containment and many other issues at long range—something which poses new problems of a different and sometimes unique nature.

But the Association will have in Doctor Hess continued strong, realistic and dedicated leadership. He will be operating from a diversified base of wide experience in family practice as well as medical education, in a private office as well as a hospital setting. He has built a record of community involvement in Bridgeport and Clarksburg over a period of several years that also will be of significant benefit.

There's an old saying that was built on the "onward and upward" principle. Pressures of the times have perhaps blunted or discouraged that kind of attitude to a distressing and even dangerous degree. It's almost certainly time to put some new emphasis on the old, positive outlook. Doctor Hess has demonstrated he can get a job done. So can the Association, if it molds the right kind of overall effort with his leadership.

THE EFFECT OF ASPIRIN ON THE FETUS

The physician has presently a choice of many drugs which he may prescribe, and more are being developed constantly. The question may be raised whether all these available drugs may be administered safely for a period of time to patients who are pregnant. It is known that some drugs when administered to pregnant women have a grave effect on the fetus. One such preparation is thalidomide. Some drugs given to pregnant women later produce harmful effects in their female offspring by producing cancer of the genital tract. It is quite possible that some other preparations may produce injurious effects when given to pregnant women.

Recently, some worthwhile observations have been reported on the effect of aspirin on the human fetus. In 1976, Slone and Shapiro[1] made a study of the effect of aspirin on a cohort of 50,282 gravida and their offspring. The women were divided into three groups: 35,418 women had received no aspirin during pregnancy; 9,736 had experienced intermediate exposure, and 5,128 received heavy exposure during the first four lunar months of pregnancy. A careful statistical analysis showed that the observed and expected number for a variety of malformations were similar in all three comparison groups.

In another study by Shapiro *et al*[2] on 41,377 gravida and their offspring, no evidence was found that aspirin taken in pregnancy is a cause of stillbirth, neonatal death, or reduced birth rate. These women were also divided into three groups: 14,956 who were not exposed to aspirin, 24,866 who had intermediate exposure to the drug, and 1,515 who were heavily exposed to aspirin. In all three groups stillbirth rates were similar. Differences in neonatal death rates and mean birth rates were slight and none was statistically significant.

In sum, the observations reported by Slone and Shapiro and their colleagues show clearly that aspirin does not affect the fetus. These studies are praiseworthy, and similar observations could well be made on certain other widely used preparations.

1. Slone, Shapiro, S: *Lancet* 1:1373 (June 26) 1976.
2. Shapiro *et al*: *Lancet* 1:1375 (June 26) 1976.

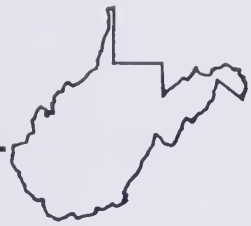
A SUGGESTION

In the view of Dr. Tom E. Nesbitt, the American Medical Association's President, the current occupant of the nation's White House should be reminded that America is built on democratic principles, with a small "d."

Not the least of these principles, Doctor Nesbitt has said, "is that strong, vigorous private associations serve as a check, and a balance, against the unreasonable growth of government and the unreasonable exercise of power and arrogance often attached thereto."

Referring to President Carter's recent verbal assault on the AMA, physicians and others, Doctor Nesbitt suggested that "the President would be better advised to devote his energies to more constructive pursuits — including the thus-far futile pursuit of his own campaign promises."

GENERAL NEWS



Program Completed For Annual Meeting Of Association

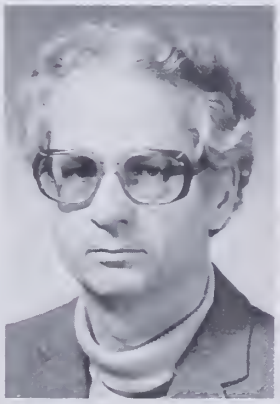
A Mississippi pediatric neurologist and a Charleston nephrologist are the final two speakers to be announced for the program of the 111th Annual Meeting of the State Medical Association to be held August 23-26 at the Greenbrier in White Sulphur Springs.

Dr. David B. Gray of Charleston, Chairman of the Program Committee, said that Dr. Gwendolyn R. Hogan of Jackson, Mississippi, will speak on "Seizures and Related Disorders" during the first general session, a "Symposium on New Methods for Treatment of Common Disorders," on Thursday morning, August 24. Doctor Hogan is Professor of Pediatrics and Director of Pediatric Neurology at the University of Mississippi at Jackson.

Gwendolyn R. Hogan, M. D.

Mary Lou L. Lewis, M. D.

Tom E. Nesbitt, M. D.



James A. Reynolds

Doctor Gray also announced that Dr. Mary Lou L. Lewis of Charleston, Medical Director, Kidney Dialysis Unit, Charleston Area Medical Center, and Clinical Professor of Medicine, Charleston Division, West Virginia University Medical Center, will follow Doctor Hogan on Thursday morning. Doctor Lewis' topic will be "Newer Methods of Treatment in Renal Diseases."

It was announced previously that Dr. Tom E. Nesbitt of Nashville, Tennessee, and James A. Reynolds of Oradell, New Jersey, will be honor guests and speakers.

Doctor Nesbitt, who was installed as President of the American Medical Association during the AMA's annual meeting in St. Louis in June, will address the first session of the House of Delegates on Wednesday afternoon, August 23.

Mr. Reynolds will deliver the sixth annual "Thomas L. Harris Address" at 9 A.M. opening exercises on Thursday, August 24. His topic will be "The Outlook for Medicine in 1984 and Beyond." This annual address was established with a bequest in the will of the late Dr. Thomas L. Harris, Parkersburg surgeon who served as President of the Association in 1945.

Board Examiner

At the University of Mississippi School of Medicine, Doctor Hogan also serves as Associate Professor of Medicine (Neurology), and Director of the Pediatric Electrodiagnostic Laboratory.

She is certified by the American Board of Psychiatry and Neurology (Neurology) and, since 1968, has been an Examiner for that board. Doctor Hogan also is certified by the American Board of Pediatrics and the American Board of Psychiatry and Neurology with special competence in Pediatric Neurology. She also is board-eligible for the American Board of Pediatrics in Neonatology.

A native of Alexandria, Virginia, Doctor Hogan received her M. D. degree in 1957 from the University of Virginia Medical School in Char-

Convention Timetable

The first general scientific session will follow 9 A.M. opening exercises on Thursday, August 24. The Friday session will begin at 9:30 A.M., and the session on Saturday, at 9:30 A.M.

The first session of the House of Delegates will be on Wednesday afternoon, August 23, beginning at 2:30. The second session will be on Saturday afternoon beginning at 2:30.

lottesville. She interned at Winchester (Virginia) Memorial Hospital, took a residency in neurology at the University of Virginia Hospital, and completed additional residencies and postgraduate work in pediatrics and neurology at the University of Rochester, Massachusetts General Hospital in Boston, Harvard Medical School and Boston City Hospital.

From 1965 to 1969, she served as Assistant (and Associate) Professor of Pediatrics and Neurology, and Director of the Newborn Nursery at West Virginia University Medical Center in Morgantown.

Doctor Hogan then returned to Boston, where she held teaching and other posts at Harvard Medical School and area hospitals. She went to the University of Mississippi in 1973.

Doctor Hogan is the author or co-author of 26 scientific articles.

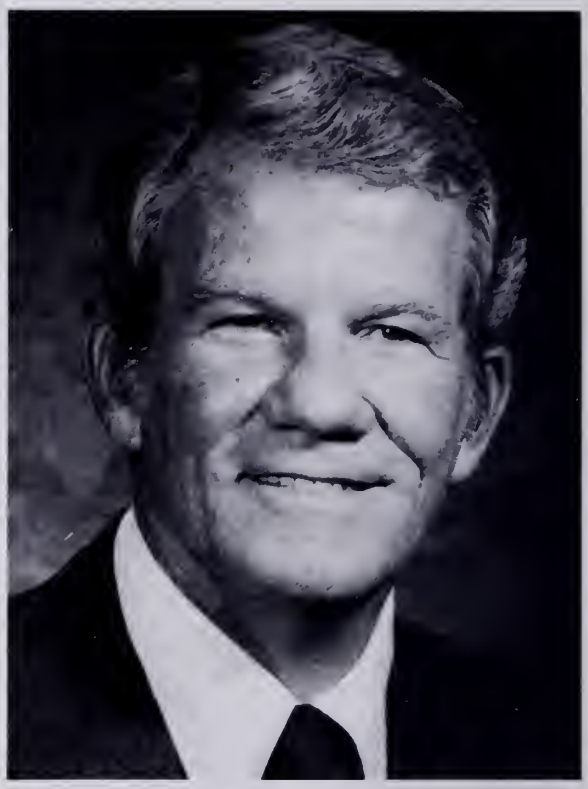
Emory University Graduate

Doctor Lewis, who also is in private group practice in Charleston, was Director of Medicine from 1971 to 1975 for the Charleston Division/WVU and CAMC, and Chief of Nephrology at those two institutions in 1975-76. Currently, she also serves as Consultant and Director for the kidney dialysis unit at St. Joseph's Hospital Center in Parkersburg.

Luncheon for Past Presidents

A luncheon honoring Past Presidents of the West Virginia State Medical Association will be held at the Greenbrier on Thursday, August 24, during the 111th Annual Meeting.

Dr. John J. Mahood of Bluefield, Immediate Past President, will preside, and invitations have been extended to all the Association's Past Presidents.



Robert D. Hess, M. D.

A native of Madison, in Boone County, Doctor Lewis was graduated in 1954 from the Duke University School of Nursing. After serving in various fields of nursing until 1960, she entered the Emory University School of Medicine, receiving her M. D. degree in 1965.

From 1965 through 1968, she was a medical intern and Research Fellow in Renal Physiology at The New York Hospital-Cornell University Medical Center. She then completed a residency in medicine and training in clinical nephrology at the University of California Medical Center of San Francisco (1968-1971).

Doctor Lewis is a member of the International Society of Nephrology, the Renal Physicians Association, American Society of Nephrology, American Society of Internal Medicine, West Virginia Kidney Foundation Medical Advisory Board, and the National Kidney Foundation Council on Dialysis and Transplant.

Some 15 Association sections and affiliated societies will hold breakfast and other meetings —mostly on Friday.

The Annual Meeting will continue through Saturday, August 26, when Dr. Robert D. Hess of Clarksburg will be installed as Association President during the second and final session of the House of Delegates. Doctor Hess will succeed Dr. Joseph A. Smith of Dunbar.

Presidential Address

Doctor Smith, a family physician, will deliver his address as the retiring Association President prior to the installation of Doctor Hess at the final House session on Saturday afternoon.

Pre-Convention Meetings

The Association's Council will have a pre-convention meeting at 9:30 A.M. on Wednesday, August 23. Its Chairman, Dr. John J. Mahood of Bluefield, will preside. The first House session will follow in Chesapeake Hall at 2:30 P.M. Doctor Smith will be the presiding officer.

At 4 P.M. on Wednesday, immediately following the first House session, an update on various aspects of the state and national professional liability insurance picture will be presented as an added feature of this year's convention. The two speakers (see separate story in this issue of the *Journal*) will be from the Hartford, Connecticut, home office of Aetna Life & Casualty. They are D. John Pecorino, LL.B., Manager of Aetna's Commercial Insurance Department, and Charles Scholhamer, M. D., Associate Medical Director. This program also will be held in Chesapeake Hall.

Aetna is the carrier for the Medical Association-sponsored professional liability insurance program.

From 6:30 to 7:30 P.M. on Wednesday, a President's Reception for Honor Guests will be held on the Old White Patio.

General Sessions

All three of this year's general sessions will be held in the theater, with the first to follow 9 A.M. opening exercises on Thursday, August 24. The other two sessions will be at 9:30 A.M. on Friday and Saturday.

Several of the guest speakers have accepted invitations to present talks at meetings of the sections and affiliated societies of the Association, most of which, as noted, are scheduled Friday.

The scientific exhibits will be located in Eisenhower Hall, adjacent to the theater. Physicians, members of the Auxiliary and their guests are urged to visit the exhibits, which will be open from 8:30 A.M. to the close of the morning sessions.

Formal Opening Exercises

Doctor Smith will call the Annual Meeting to order at the 9 A.M. session on Thursday, with Dr. Joseph T. Skaggs of South Charleston to give the invocation. Doctor Smith will make welcoming remarks and Doctor Gray and other members of his committee will be introduced. The first general session will be held following the address by Mr. Reynolds.

Dr. Maurice A. Mufson of Huntington, Chairman, Department of Medicine, Marshall University School of Medicine, will serve as moderator for the first general session program. The speakers, in addition to Doctors Hogan and Lewis, as announced above, and their topics will be:

"Management of Chronic Pulmonary Disease" —Ruy V. Lourenco, M. D., Professor and Chairman, Department of Medicine, Abraham Lincoln School of Medicine, University of Illinois, Chicago, and "An Overview of Hypertension"— John W. Eckstein, M. D., Dean, College of Medicine, The University of Iowa, Iowa City.

Thursday Afternoon

A luncheon honoring Past Presidents of the State Medical Association will be held at 12:30 P.M. Thursday in the Tyler Room, with Doctor Mahood scheduled to preside. The Association's Resolutions Committee, with Dr. Richard E. Flood of Weirton presiding, will meet at 2 P.M. Thursday in the Directors' Room.

Friday Breakfast Meetings

All but one (to be noted) of the Friday morning breakfast meetings will begin at 7:30. The meetings, speakers (where scheduled) and their topics follow:

West Virginia Academy of Ophthalmology and Otolaryngology, Dr. R. Lawrence Dunworth of Huntington presiding, Washington Room;

Section on Internal Medicine, Dr. Harold Selinger of Charleston presiding, Lee Room;

West Virginia Obstetrical and Gynecological Society, Dr. Samuel J. Bracken of Wheeling pre-

House of Delegates To Meet Twice During Meeting

The first session of the House of Delegates during the Annual Meeting at the Greenbrier will be convened at 2:30 P.M. on Wednesday, August 23. The second and final session of the House of Delegates will be held at 2:30 P.M. on Saturday, August 26.

Nominating Committee To Meet On Friday, August 25

The State Medical Association's Committee on Nominations will hold a 5 P.M. meeting on Friday, August 25, in the Directors' Room of the Greenbrier.

The Committee will make nominations to the House of Delegates for President Elect, Vice President and Treasurer, and for Delegate and Alternate Delegate to the American Medical Association.

Association By-Laws also provide that nominations may be made from the floor for these offices, to be filled by the House in balloting at its final session on Saturday, August 26, the final day of the Association's 111th Annual Meeting.

Dr. William E. Gilmore of Parkersburg will serve as Chairman of the Committee on Nominations, with other members to include: Joseph T. Mallamo, Fairmont; L. Walter Fix, Martinsburg; Wallace B. Murphy, Grafton; Lyle D. Vincent, Parkersburg; Winfield C. John, Huntington; Walter E. Klingensmith, Beckley, and Arthur E. Levy, Williamson.

In addition, one of the Kanawha Medical Society's two Councilors will serve on the Committee under provisions of the By-Laws. That representative will be Dr. John B. Markey of Charleston.

siding; individual case histories and general discussion, Tyler Room;

Section on Dermatology, Dr. Nazem Abraham of Huntington presiding; presentation of case histories by individual members, including biopsies and clinical photographs; Moderator, William A. Welton, M. D., Professor and Chairman of Dermatology, West Virginia University Medical Center, Morgantown, assisted by staff residents, Jackson Room;

Section on Surgery, Dr. Robert J. Reed III of Wheeling presiding; "Pneumoperitoneum as Preparation for Giant Hernia Repair," Edward E. Mason, M. D., Iowa City, Iowa, Buchanan Room, and

Section on Urology (*8 A.M.*), Dr. James W. Lane of Charleston presiding; "Hematuria and Proteinuria in Children," Mary Lou L. Lewis, M. D., Charleston, Directors' Room.

Second General Session

Doctor Gray will be the moderator at the second general session beginning at 9:30 A.M. on Friday. The speakers and their topics will be:

"High-Risk Pregnancy"—David J. S. Hunter, M. D., Associate Professor, Department of Obstetrics and Gynecology, and Director of Fetal-Maternal Medicine, WVU Medical Center, Morgantown; "Surgical Treatment of Obesity"—Edward E. Mason, M. D., Professor of Surgery, The University of Iowa, Iowa City; and "The Medical Examiner System of West Virginia"—Irvin M. Sopher, M. D., Chief Medical Examiner, State of West Virginia, Charleston.

Friday Afternoon Schedule

The Association's Publication Committee, with Dr. Stephen D. Ward of Wheeling, Chairman, presiding, will meet at noon on Friday in the Buchanan Room. Doctor Gray, Chairman, will preside at a meeting of the Cancer Committee at 12:15 P.M. Friday in the Washington Room.

The Board of Trustees of the West Virginia Medical Institute, Inc., with Dr. Harry S. Weeks, Jr., of Wheeling presiding, will meet at 12:30 P.M. Friday in the Directors' Room.

Also meeting Friday afternoon will be the following sections and affiliated societies of the Association:

West Virginia Chapter, American College of Emergency Physicians, Dr. William E. Walker of Huntington presiding; "Pre-Hospital Care—*Quo Vadis?*," Ronald D. Stewart, M. D., Pittsburgh, 2 P.M., Pierce Room;

Section on Orthopedic Surgery, Dr. Robert N. Clark of Morgantown presiding; "Diagnosis of Infected Non-Union of the Tibia" and "The Floating Knee," John A. Cardea, M. D., Richmond, Virginia; "A Look at Pathological Hip Fractures," Robert P. Durning, M. D., Morgan-

The 1978 Program Committee

Dr. David B. Gray of Charleston is Chairman of the Program Committee for the 111th Annual Meeting of the West Virginia State Medical Association. Other members of the Committee are Drs. Aarom Boonsue, Pt. Pleasant; Robert D. Hess, Clarksburg; James T. Hughes, Ripley; Barbara Jones, Morgantown, and Maurice A. Mufson, Huntington.

No Registration Fee for Members

Members of the West Virginia State Medical Association will not be assessed a registration fee in connection with the 111th Annual Meeting at the Greenbrier in White Sulphur Springs, August 23-26.

Interns, residents and medical students also will be registered without charge.

There will be a registration fee of $50 for out-of-state physicians attending the meeting.

town, and "Psychological Aspects of Orthopedics," Peter K. Thrush, M. D., Morgantown, 2 P.M., Tyler Room;

West Virginia District Branch, American Psychiatric Association, Dr. Donald C. Carter of Morgantown presiding; "Suggestions for a Psychiatrist's Direct and Cross-Examination While on the Witness Stand," Philip J. Marco, M. D., Columbia, Missouri, 2 P.M., Lee Room;

West Virginia Chapter, American Academy of Pediatrics, Dr. Herbert H. Pomerance of Charleston presiding; "Newer Concepts, Etiology of Reye's Syndrome," Gwendolyn R. Hogan, M.D., Jackson, Mississippi, and

West Virginia Chapter, American Society of Internal Medicine, Dr. Richard G. Starr of Beckley presiding, 4 P.M., Jackson Room.

The Association's Committee on Nominations, with Dr. William E. Gilmore of Parkersburg presiding, will meet at 5 P.M. in the Directors' Room.

Saturday Morning Schedule

Dr. Karl L. Klapproth of Charleston will preside at a meeting of the West Virginia Association of Pathologists at 7:30 A.M. in the Directors' Room.

The West Virginia Radiological Society, with Dr. Orlando F. Gabriele of Morgantown presiding, will meet at 8 A.M. in the Tyler Room. The guest speaker will be Reed P. Rice, M. D., of Durham, North Carolina, whose subject will be "The Radiologic Evaluation of the Acute Abdomen."

The third general session will be held at 9:30 A.M. on Saturday in the theater, with Karen A. Zupko, Director of the AMA's Department of Practice Management, speaking. Ms. Zupko will discuss "Personnel: What You Need for Office Efficiency" and, following a coffee break from 10:15 to 10:30, "Patient Relationships: Communications, Information, Rapport."

Saturday Afternoon

The West Virginia State Society of Anesthesiologists, with Dr. William N. Walker, Jr., of Clarksburg presiding, will meet at noon on Saturday in the Directors' Room. The guest speaker will be Dr. Edward E. Mason of Iowa City, Iowa, whose subject will be "Pulmonary Considerations in Surgical Treatment of Obesity."

Second House of Delegates Session

Doctor Smith again will be the presiding officer at the second and final House of Delegates session in Chesapeake Hall at 2:30 P.M. on Saturday.

Along with his Presidential Address and the installation of Doctor Hess, the agenda will include election of other Association officers and consideration of several business items.

Medical School Alumni Events

Cocktail parties will be held by the West Virginia University School of Medicine's Alumni Association Thursday evening, and by the University of Virginia Medical School Foundation and the West Virginia Chapter, Medical College of Virginia Alumni Association, Friday evening.

Dr. Clark K. Sleeth will be in charge of the WVU festivities in the West Virginia Room Thursday at 6:30 P.M. Dr. William C Morgan will serve in the same role for the University of Virginia affair at 6 P.M. Friday in Chesapeake Bay. Dr. Buford W. McNeer will be in charge of the Medical College of Virginia event at 6:30 P.M. Friday on the Old White Patio.

Friday Auxiliary Dance

The Auxiliary to the State Medical Association has scheduled a dance, with Don Boyd and his Orchestra, beginning at 10 P.M. Friday in Chesapeake Hall. The Raleigh County Auxiliary will be the host, with Mrs. Richard D. Richmond of Beckley serving as Chairman. All physicians, their wives and others registered for the State Medical Association convention are invited.

Saturday Evening Reception

New and continuing officers of the State Medical Association will be honored at a cocktail party and reception from 6:30 to 7:30 P.M. Saturday on the Colonial Hall Terrace. All members of the Association and Auxiliary and their families, representatives of scientific exhibitors and convention guests are cordially invited.

Advance registration for the Annual Meeting at the Greenbrier has been heavy. As this issue of the *Journal* went to press, more than 600 persons had made reservations.

Continuing Education Activities

Here are the continuing medical education activities listed primarily by the West Virginia University School of Medicine for part of 1978, as compiled by Dr. Robert L. Smith, Assistant Dean for Continuing Education. The schedule is presented as a convenience for physicians in planning their continuing education program. (Other national, state and district medical meetings are listed in the *Medical Meetings* Department of *The Journal.*)

The program is tentative and subject to change. It should be noted that weekly conferences also are held on the Charleston and Wheeling campuses as well as in Morgantown. Further information about these may be obtained from: Division of Continuing Education, WVU Medical Center, 3110 MacCorkle Avenue, S.E., Charleston 25304; Office of Continuing Medical Education, WVU Medical Center, Morgantown 26506; or, Office of Continuing Medical Education, Wheeling Division, WVU School of Medicine, Ohio Valley Medical Center, 2000 Eoff Street, Wheeling 26003.

Sept. 7, 8	Morgantown	Hal Wanger Family Practice Conference
Sept. 15	Morgantown	Cleft Palate Teaching Day
Sept. 22, 23	Wheeling	Seminar on Obstetrics and Gynecology
Sept. 15, 16	Charleston	Emergency Care Seminar
Oct. 5	Morgantown	Annual Pediatric Day
Oct. 6, 7	Morgantown	Critical Care Symposium
Oct. 14	Wheeling	Medicine Day Seminar
Oct. 20, 21	Charleston	Medical and Social Problems of the Elderly
Oct. 27, 28	Morgantown	American College of Surgeons

State Medical Association Lists Names of New Members

The following is a list by component societies of new members of the West Virginia State Medical Association elected from January 1 through June 30, 1978:

Brooke

Alaud Din ..... Wellsburg

Cabell

Larry Allen Caserta ..... Huntington
Francisco A. Constantino ..... Barboursville
Jon D. Cooksey ..... Huntington
Robert James Crisalli ..... "
Vasilios P. Dross ..... "
Maria C. Estacio-Suarez ..... "
Seyd H. Hadi-Sadegh ..... "
John Christopher Hough ..... Hamlin
John C. Huntwork ..... Huntington
Jose M. Maia ..... "
Thomas E. McCay IV ..... "
Sally L. R. Oakes ..... "
Roberta G. Rice ..... "
Donald S. Robinson ..... "
Mauricio N. Saleme ..... "
Imre Szendi-Horvath ..... "
Robert Bruce Walker ..... Hamlin
Joseph William Werthammer ..... Huntington

Central West Virginia

Robert E. Fleer ..... Summersville

Eastern Panhandle

Michael D. Hall ..... Hagerstown, Maryland
Evan B. Hume ..... Shepherdstown
Hernando Jimenez ..... Martinsburg

Fayette

Daniel B. Doyle ..... Oak Hill
W. M. Jagdon ..... " "
Eugene Wei-YuKao ..... Montgomery
Mohammad A. Sobhan ..... Oak Hill

Greenbrier Valley

W. Dickson Moss III ..... Ronceverte

Hancock

Manuel Figallo ..... Weirton
Lloyd B. McCabe ..... "
Shaukat H. Minhas ..... "
Gurdev S. Purewal ..... "
John R. Shannon ..... "

Harrison

James E. Bland ..... Clarksburg
Arthur L. Calhoun ..... West Union
Kasin E. Chai ..... Clarksburg
Oranee E. Chai ..... "
James Genin ..... "
John A. Jupin ..... "
Charles A. Lefebure ..... "
Emil L. Mantini ..... "

Kanawha

Bruce Lyle Berry ..... Charleston
Stephen A. DeGray ..... South Charleston
Stephen R. Grubb ..... Charleston
William L. Harris ..... "
Richard D. Hayes ..... Hurricane
John P. Hutton ..... Charleston
Vijay K. Jain ..... "
Roberto Kusminsky ..... "

Thomas S. Lanava	Charleston
David P. Lee	"
Carlos E. Lucero	"
Tchuoc Poin Ly	"
Barbara U. Morgan	"
Nolan C. Parsons, Jr.	"
Kathleen V. Previll	"
George E. Pickett	"
William T. Tweel	Hurricane
Daniel D. Upthegrove	Charleston
Carolyn Sue Warren	South Charleston
Edward R. Wheatley	Charleston
Rodney R. Williams	"

Logan

Sterjo Kondovski	Logan
Harshadrai Parmar	Man

Marion

Abdel Bakhos	Fairmont
Hannah Hui	"
Paul L. Hung	"
G. David Leveaux	"
S. L. Magunia	"
Vinod D. Modi	"
Phanlobh Vichaikul	"

McDowell

Isabelita DeMesa	Welch
Mohmedahmed U. Khalak	"
Kanchanlal S. Patel	"

Mercer

Edward M. Bowles, Jr.	Bluefield
Richard E. Davenport	Princeton
Charles Horn	Bluefield
Thomas J. Park	Princeton
B. B. Regis	"

Mingo

Stephen Lau	South Williamson, Kentucky
Jenq-Sheng Liu	Williamson

Monongalia

John A. Belis	Morgantown
Robert Bettinger	"
Terring W. Heironimus III	"
Jin-Chul Kim	"
John Palmer D. Shemo	"
George E. Snider, Jr.	"
Barbara Tenney	"
Patricia W. Williams	"

Ohio

John W. Durkin, Jr.	Wheeling
John P. Franz	"
Thomas G. Kenamond	"
D. L. Latos	"
R. Wade Ortel	"
Drake Richey	St. Clairsville, Ohio
Alan Marshall Ruben	Wheeling
Charles Henry Staab	"
John B. Talbott	"
Richard F. Terry	"
Paresh K. Thakkar	St. Clairsville, Ohio

Parkersburg Academy

Robert W. Azar	Parkersburg
Joseph L. Boggs	"
Donald R. Lantz	"
Gary W. Miller	"

Potomac Valley

Malcolm M. Ault	Petersburg

Raleigh

Maurice Bassali	Beckley
Henry Maynard Bellamy, Jr.	"
Eileen C. Catterson	Rhodell
Teodoro D. Jimenez	Beckley
Andrew E. Landis	"
Deborah J. McCloud	"
D. A. Patel	"
Norman W. Taylor	"

Summers

Suthipan Chevathanarat	Hinton

Tygart's Valley

J. J. Kuo	Elkins
Peter M. Tanna	Green Bank
Sawitri Werasophon	Grafton
Som Chai Werasophon	"

Additions to Medical Faculty Named at Marshall

The Marshall University School of Medicine will have seven new faculty members—including a Huntington native—joining its staff later this summer, Dr. Robert W. Coon, Dean of the School, has announced.

Five of the new personnel will be additions to the Department of Medicine staff, while one each will be added to the Departments of Pediatrics and Pharmacology.

Several of these doctors have accepted joint appointments with the medical school and the Huntington Veterans Administration Hospital.

"Sharing this medical expertise is just one of the ways the Marshall Medical School and the

Drs. Stephen D. Ward, left, of Wheeling, the West Virginia State Medical Association's Vice President, and Dr. Joseph A. Smith of Dunbar, the Association President, discuss matters of common interest with Dr. David S. Fox of Chicago, President of the Illinois State Medical Society, before the House of Delegates convened for one of its four sessions during the American Medical Association's Annual Meeting in June in St. Louis.

VA hospital benefit each other," said Dr. Herbert H. Spencer, Chief of Staff at the hospital. "It's a very efficient means to enhance both our staffs," he added.

The new medical school appointments include:

Dr. Bruce Chertow, Professor of Medicine and Chief of the Endocrinology Section.

Dr. Robert B. Belshe, Associate Professor of Medicine and Chief of the Infectious Diseases Section.

Dr. Michael J. Kinney, Associate Professor of Medicine and Chief of the Nephrology Section.

Dr. Nancy Scher, Assistant Professor of Medicine.

Dr. Lee P. Van Voris, Assistant Professor of Medicine.

Dr. Richard L. Curry, Assistant Professor of Pediatrics and Director of Pediatric Ambulatory Care.

Dr. Donald Melnick, Assistant Professor of Pharmacology.

Doctor Chertow currently is Associate Professor of Medicine at the University of Illinois College of Medicine and Staff Physician in Nuclear Medicine and Endocrinology and Metabolism at the VA West Side Hospital in Chicago. He will be Staff Physician in Endocrinology at the Huntington VA Hospital. Doctor Chertow earned his M. D. degree from the University of Illinois.

Doctor Belshe, who will serve the Huntington VA Hospital as a Staff Physician in Medicine, also earned his M. D. degree from the University of Illinois. He currently is a Research Associate with the U. S. Public Health Service at the National Institutes of Health in Bethesda, Maryland.

A Clinical Assistant Professor of Medicine at the State University of New York (SUNY) Downstate Medical Center in Brooklyn, Doctor Kinney also is Associate Chief, Renal Service, for the U. S. Public Health Service Hospital on Staten Island. A medical graduate of the University of Chicago, he will be a Staff Physician in Nephrology at the Huntington VA Hospital.

A graduate of the University of Pennsylvania School of Medicine, Doctor Scher most recently has been a fellow in hematology-oncology at the Philadelphia school.

A SUNY Downstate Medical graduate, Doctor Van Voris has been an instructor and fellow in medicine for the Infectious Disease Unit of the University of Rochester School of Medicine and Dentistry. He also has been appointed a Staff Physician in Infectious Diseases at the Huntington VA Hospital.

Dr. Richard E. Flood of Weirton, in the left photo, makes his report to the House of Delegates as Chairman of the Committee on Credentials during the American Medical Association's Annual Meeting in St. Louis in June. Behind Doctor Flood, one of the West Virginia State Medical Association's two Delegates to the AMA, is Dr. William Y. Rial of Swarthmore, Pennsylvania, Speaker of the House. In the right photo, Doctor Flood congratulates the AMA's new President, Dr. Tom E. Nesbitt of Nashville, Tennessee, after his June 21 inauguration. Doctor Nesbitt will address the State Medical Association's House of Delegates at its first of two Annual Meeting sessions on August 23 at the Greenbrier.

Doctor Curry, a graduate of Buffalo of Wayne High School and Marshall University, earned his M. D. degree from West Virginia University School of Medicine. He has been a Staff Pediatrician for the Naval Regional Medical Center at Portsmouth, Virginia.

A medical graduate of Loma Linda (California) University, Doctor Melnick most recently was a resident in medicine at the Medical Center Hospitals of the University of Vermont. He will be a clinical pharmacologist at the VA Hospital.

Auxiliary Completes Program For 54th Annual Meeting

Mrs. Manuel A. Bergnes of Norristown, Pennsylvania, will be among honor guests when the Auxiliary to the West Virginia State Medical Association holds its 54th Annual Meeting at the Greenbrier in White Sulphur Springs August 23-26.

The meeting again will be held concurrently with the Annual Meeting of the State Medical

Mrs. Manuel A. Bergnes

Mrs. M. Bruce Martin

Association. Mrs. Bergnes was installed in June as the new President of the American Medical Association Auxiliary.

Also addressing the Auxiliary will be Mrs. M. Bruce Martin of Huntington, President of the Auxiliary to the Southern Medical Association.

More than 200 wives of physicians are expected to attend the Auxiliary's business sessions, over which Mrs. Joseph T. Mallamo of Fairmont, the Auxiliary's President, will preside.

Preconvention Meetings

An invitation has been extended to all Auxiliary members to attend the first session of the State Medical Association's House of Delegates on Wednesday, August 23, at 2:30 P.M. Dr. Tom E. Nesbitt, President of the American Medical Association, will be the principal speaker.

Mrs. Mallamo then will preside at a 4 P.M. preconvention Auxiliary Board meeting in the Fillmore-Van Buren Rooms.

Opening Convention Exercises

Members of the Auxiliary also have been invited to attend formal opening ceremonies of the State Medical Association's 111th Annual Meeting at 9 A.M. on Thursday, August 24, in the theater. James A. Reynolds of Oradell, New Jersey, Executive Editor of Medical Economics, will deliver the sixth annual "Thomas L. Harris Address."

Following the opening exercises, the Auxiliary members will go to the Fillmore-Van Buren Rooms for the formal opening of their convention, with Mrs. Mallamo in charge.

First General Session

The keynote address by Mrs. Bergnes will highlight the initial session at 10 A.M. Dr. Joseph A. Smith of Dunbar, President of the State Medical Association, will be recognized for brief remarks.

Mrs. Bergnes has long been a leader at all levels of the Auxiliary. She has been a member of the Montgomery County (Pennsylvania) Auxiliary since 1949 and served a term as President. In addition, she has been Chairman of her county auxiliary's Community Service and Health Careers committees, and was instrumental in establishing a scholarship program for nursing students.

On the state level, Mrs. Bergnes has served as President, Parliamentarian, and Chairman of the Bylaws and Nominating committees. Currently, she sits on the state Bylaws Committee.

Nationally, she has served on the Bylaws and Home-Centered Health Care committees, and as Director, Delegate to the White House Conference on Aging, Historian, and Treasurer.

Interest In Care For Aging

A dedicated advocate of home health care for the aging, Mrs. Bergnes helped found and served as President of the Montgomery County Homemaker-Home Health Aide Service. She was President of the Pennsylvania Council for Homemaker-Home Health Aide Service for five years, and recently was re-elected to the Board of Directors of the National Council for Homemaker-Home Health Aide Services. She was appointed to the Task Force on In-Home Services of the Governor's Advisory Council on Aging, and rep-

Mrs. Joseph T. Mallamo

resents the AMA Auxiliary on the Executive Committee of NVOILA — National Voluntary Organizations for Independent Living for the Aging.

Born Muriel Ahrend in Staten Island, New York, Mrs. Bergnes graduated magna cum laude from Wagner College in New York, where she met her husband. A pathologist, Doctor Bergnes is Director of Laboratory Services at Sacred Heart Hospital in Norristown and Attending Pathologist at Phoenixville Hospital in Phoenixville, Pennsylvania. The couple has a daughter, Linda, who majored in Spanish in college and currently is living and working in New York City.

Mrs. Bergnes' interests include music, bird-watching, travel, and history.

Other Opening-Session Items

Other opening-session items will include the introduction of the convention Co-Chairmen, Mrs. Harry C. Fleming and Mrs. Kenneth D. Bailey, both of Fairmont; reports from officers and committee chairmen, recommendations from the preconvention board meeting, election of the 1979 Nominating Committee, and introduction of component Auxiliary Presidents by the Regional Directors.

Bridge, Past Presidents' Breakfast

A bridge tournament beginning at 2 P.M. will be held on Thursday in the Trellis Lobby. The Marion County Auxiliary will serve in the host role, with Mrs. William T. Lawson of Fairmont as Chairman.

At 8 A.M. on Friday, August 25, the Past Presidents' breakfast will be held in the Virginia Room, with Mrs. J. L. Mangus of Charleston, Immediate Past President of the Auxiliary, presiding.

Second General Session

The Second General Session at 9:30 A.M. on Friday in the Fillmore-Van Buren Rooms again will have Mrs. Mallamo presiding, with a highlight to be the address by Mrs. Martin.

The session will begin with an address by Dr. George E. Pickett, Director of the West Virginia Department of Health.

Other activities will include acknowledgement by representatives of the West Virginia University and Marshall University Schools of Medicine of AMA-ERF grants stemming from Auxiliary efforts. Mrs. Charles E. Andrews of Morgantown is state AMA-ERF Chairman.

Mrs. Bergnes will install Mrs. Robert J. Reed III of Wheeling as the new Auxiliary President. Other officers will be elected after a report from the Nominating Committee, and Mrs. Mallamo will receive the Past President's Pin from Mrs. Mangus. Mrs. Reed will deliver her inaugural address.

Friday Social Function

The Ohio County Auxiliary, with Mrs. Stephen D. Ward of Wheeling as Chairman, will be host for tennis on Friday afternoon. Golf (for tournament) may be played either Thursday or Friday.

A dance, with music by Don Boyd and his Orchestra, will be held from 10 P.M. to 1 A.M. in Chesapeake Hall. There will be a "Little or No Talent Show" during intermission. The Raleigh County Auxiliary, with Mrs. Richard D. Richmond of Beckley as Chairman, will be host.

Postconvention Board Meeting

Mrs. Reed will preside at the postconvention conference and board meeting at 10 A.M. on Saturday, August 26, in the Fillmore-Van Buren Rooms.

Saturday Afternoon Agenda

Auxiliary members are invited to attend the second and final session of the State Medical Association's House of Delegates on Saturday at 2:30 P.M., at which time Dr. Robert D. Hess of

Clarksburg will be installed as the Association's President, and other Association officers will be elected.

Other Convention Matters

Those Auxiliary members who plan to participate in bridge, golf and tennis are urged to sign up in advance at the registration desk.

Sports Activities Scheduled During Annual Meeting

Competition in golf, tennis and skeet will be worked into annual meetings of the West Virginia State Medical Association and its Auxiliary August 23-26 at the Greenbrier in White Sulphur Springs.

Dr. L. Dale Simmons again will be in charge of the men's Medical Golf Tournament, which he won last year with a 78. Doctor Simmons said that players will be assessed the usual $5 registration fee, and may play their rounds during any morning or afternoon on Thursday through Saturday, August 24-26.

Specific starting times and other rules will be observed, and tournament competitors must inform the starter when they begin their official 18 holes of medal play. All tournament rounds must be completed by 4 P.M. on Saturday to permit the awarding of golf and other prizes during an evening reception that will honor new officers of the Medical Association and Auxiliary.

Mrs. William E. Gilmore of Parkersburg, who had a low gross score of 80, will be seeking at least her third women's golf title in a row, with the tournament play scheduled for Thursday and Friday afternoons.

Dr. Harold Selinger of Charleston once again will be in charge of the men's tennis play, planned for Thursday afternoon; with Mrs. Stephen D. Ward of Wheeling directing the women's tournament. Both men's and women's competition will be limited to doubles.

Drs. Ray S. Greco of Weirton and Maurice A. Mufson of Huntington won last year's Association tennis honors, with Mrs. Ward and Mrs. Nicholas D. Zambos of Beckley the Auxiliary champions.

Skeet competition for the men, being arranged by Dr. O. M. Harper of Clendenin, will include a 100-bird shoot with entrants using either 20- or 12-gauge shotguns. The contestants will be divided into two classes in vying for trophies, with one group to include those who never have won a registered "shoot," and the other limited to the more accomplished competitors.

Review A Book

The following books have been received by the Headquarters Office of the State Medical Association. Medical readers interested in reviewing any of these volumes should address their requests to Editor, *The West Virginia Medical Journal*, Post Office Box 1031, Charleston 25324. We shall be happy to send the books to you, and you may keep them for your personal libraries after submitting to *The Journal* a review for publication.

Genetic Screening: Programs, Principles, and Research, by the National Academy of Sciences (Committee for the Study of Inborn Errors of Metabolism, Division of Medical Sciences, Assembly of Life Sciences, National Research Council). 388 pages. 2101 Constitution Avenue, N.W., Washington, D. C. 20418. 1975.

Review of Medical Microbiology, 13 Edition, by Ernest Jawetz, Ph. D., M. D.; Joseph L. Melnick, Ph. D.; and Edward A. Adelberg, Ph. D. 550 pages. Price $12. Lange Medical Publications, Los Altos, California 94022. 1978.

The Scientist: A Novel Autobiography, by John C. Lilly, M. D. 210 pages. Price $10. J. B. Lippincott Company, 521 Fifth Avenue, New York, New York 10017. 1978.

Basic and Clinical Immunology, 2nd Edition, by H. Hugh Fudenberg, M. D.; Daniel P. Stites, M. D.; Joseph L. Caldwell, M. D., and J. Vivian Wells, M. D. 758 pages. Price $14.50. Lange Medical Publications, Los Altos, California 94022. 1978.

The Malpractitioners, by John Guinther. 345 pages. $10. Doubleday & Company, Inc., 245 Park Avenue, New York, New York 10017.

Family Practice Conference

The Fourth Annual Hal Wanger Family Practice Conference will be held September 7-8 at the West Virginia University Medical Center Auditorium in Morgantown. The conference is sponsored by the WVU School of Medicine, the WVU Office of Continuing Medical Education, and the West Virginia Chapter, American Academy of Family Physicians.

The program meets the criteria for 14 hours of credit in Category 1 for the Physician's Recognition Award of the American Medical Association; is acceptable for 14 prescribed hours by the AAFP, and is approved for 1.4 WVU CEU's.

Medical Association Announces Winners Of Scholarships

Four 1978 scholarships for students entering West Virginia medical schools have been awarded by the State Medical Association.

Dr. John Mark Moore of Wheeling, Chairman of the Association's Committee on Medical Scholarships, announced these winners who will receive grants of $1,250 for each of their four years at the medical school noted:

Veda Lynn Ackerman of Wheeling, Rosanna Sikora of Weirton and Anthony Lee Burke of Charleston, all accepted at the West Virginia

Veda Lynn Ackerman

Darrell W. Jordan

University School of Medicine; and Darrell William Jordan of Ona, Cabell County, who will enter the Marshall University School of Medicine.

Miss Ackerman, daughter of the late Mr. and Mrs. David W. Ackerman, has an undergraduate degree from West Liberty State College and is currently employed as a medical laboratory technician in Wheeling.

Miss Sikora, a West Virginia University graduate with a major in biology, also is working in a medical laboratory position. She is the daughter of Mr. and Mrs. Edward J. Sikora.

Burke, a West Virginia Wesleyan graduate with a B. S. degree in biology and a B. A. degree in chemistry, is presently employed at Union Carbide Corporation's Technical Center in South Charleston. He is the son of Mr. and Mrs. Paul Lee Burke.

Jordan, the first Marshall School of Medicine enrollee to receive a Medical Association scholarship, has an undergraduate degree from Marshall in zoology. He is the son of Mr. and Mrs. Raymond G. Jordan.

Until 1974, the Medical Association awarded two scholarships annually. It then increased the

Rosanna Sikora

Anthony L. Burke

number to four with a goal of encouraging greater numbers of young physicians to establish practice in West Virginia.

As a result of House of Delegates action during the 1976 Annual Meeting of the Association at the Greenbrier, and in the wake of a recommendation by the Association's Committee on Medical Scholarships, the annual scholarship value was increased from $1,000 to $1,250, effective with the 1978-79 term, for all 16 recipients (four in each medical school class.).

Under provisions of their scholarship agreement, recipients must agree to practice in West Virginia for four years following graduation and completion of any postgraduate training and/or military obligations.

The Committee on Scholarships conducted interviews of applicants from this fall's first-year WVU and Marshall Schools of Medicine classes June 10-11 in Parkersburg. Other Committee members are Drs. R. L. Chamberlain of Buckhannon; Marshall J. Carper and Kenneth G. MacDonald, Sr., both of Charleston; James T. Hughes of Ripley; John M. Daniel of Beckley; William E. Gilmore of Parkersburg; Thomas J. Holbrook of Huntington, and Clark K. Sleeth of Morgantown.

State Pathologists Group Elects Officers

The West Virginia Association of Pathologists has elected officers for 1978-79. They are:

Drs. Karl L. Klapproth, Charleston, President; Cordell A. De La Pena, Clarksburg, Vice President, and Nathaniel F. Rodman, Jr., Morgantown, Secretary-Treasurer.

Liability Insurance Update Set For Annual Meeting

An update on various aspects of the state and national professional liability insurance picture will be an added feature of this year's 111th Annual Meeting of the West Virginia State Medical Association at the Greenbrier.

The 4 P.M. program on Wednesday, August 23, in Chesapeake Hall will follow immediately

D. John Pecorino, LL.B.

Charles F. Scholhamer, M.D.

the first session of the Association's House of Delegates. The speakers will be from the Hartford, Connecticut, home office of Aetna Life & Casualty.

D. John Pecorino, LL. B., Manager of Aetna's Commercial Insurance Department, will speak on "State and National Trends in Professional Liability Insurance." Charles F. Scholhamer, M. D., Associate Medical Director of the company, will follow with a discussion of "Malignancy in Malpractice Claims."

Aetna is the carrier for the Medical Association-sponsored professional liability insurance program set up for its members by action of the House of Delegates in August, 1972.

Pecorino, who received his LL. B. degree from John Marshall Law School in 1949, served as attorney and senior attorney with Aetna before becoming manager in 1949. He is responsible for directing the organization and implementation of loss control and education programs for state medical societies and all hospital programs on professional liability insurance embraced by Aetna.

Doctor Scholhamer joined Aetna in 1971 as assistant medical director after practicing medicine for 29 years, and was named to his current position in 1975. A graduate of the Yale University School of Medicine, he is a member of the New Haven Medical Association, Connecticut State Medical Society and the American Academy of Pediatrics.

Medical Meetings

Aug. 16-19—Vascular Disease—Mechanisms and the Basis for Therapy (Am. Heart Assn.), Hilton Head, S. C.

Aug. 23-26—111th Annual Meeting, W. Va. State Medical Assn., White Sulphur Springs.

Sept. 10-14—Am. Academy of Ophthalmology & Otolaryngology (Otolaryngology Section), Las Vegas.

Sept. 19-21—Am. College of Emergency Physicians, Houston.

Sept. 21-23—Cardiology for the Clinician (Am. Heart Assn.), Williamsburg, Va.

Sept. 22-24—Am. Neurological Assn., Washington, D. C.

Sept. 26-28—Kentucky Med. Assn., Lexington.

Sept. 24-30—Am. College of Gastroenterology, Denver.

Sept. 25-28—AAFP, San Francisco.

Sept. 29-30—AMA Medical Staff Leadership Seminar, New York City.

Sept. 29-30—ASIM, Orlando, Fla.

Oct. 15-19—Am. Public Health Assn., Los Angeles.

Oct. 20-21—Am. Geriatrics Society, Baltimore.

Oct. 21-25—Am. Society of Anes., Chicago.

Oct. 22-25—Indiana State Medical Assn., Clarksville.

Oct. 22-26—Am. Academy of Ophthalmology & Otolaryngology (Ophthal. Section), Kansas City, Mo.

Oct. 25-27—Cardiology Conference (Am. Heart Assn., University of Pittsburgh, W. Va. & Pa. Affiliates, AHA), White Sulphur Springs.

Oct. 25-29—Am. Academy of Child Psychiatry, San Diego.

Oct. 27-29—D. C. Medical Society, White Sulphur Springs, W. Va.

Oct. 30-Nov. 1—Pa. Med. Society, Lancaster.

Nov. 2-5—Med. Society of Virginia, Williamsburg.

Nov. 11-14—Southern Medical Assn., Atlanta.

Dec. 7-10—AMA Winter Scientific Session, Las Vegas.

1979

Jan. 26-28—12th Mid-Winter Clinical Conference, Charleston.

March 30-April 1—W. Va. Chap., AAFP, Charleston.

CONVENTION PROGRAM

111th ANNUAL MEETING

of the

West Virginia State Medical Association

THE GREENBRIER, WHITE SULPHUR SPRINGS

August 23-26, 1978

WEDNESDAY MORNING

August 23

(Eastern Daylight Time)

9:00-5:00—Registration, Registration Lobby.

9:30—Pre-Convention Meeting of the Council. John J. Mahood, M.D., *Presiding* (Lee Room, with Luncheon in Fillmore Room).

WEDNESDAY AFTERNOON

2:30—First Session of the House of Delegates. Joseph A. Smith, M.D., *Presiding* (Chesapeake Hall).

Invocation—Carl B. Hall, M.D.

Address: Tom E. Nesbitt, M.D., President, American Medical Association.

Presentation of AMA-ERF Grants to the West Virginia University and Marshall University Schools of Medicine.

Business Meeting.

4:00—"State and National Trends in Professional Liability Insurance," D. John Pecorino, LL.B., Manager, Commercial Insurance Department; and "Malignancy in Malpractice Claims," Charles F. Scholhamer, M.D., Associate Medical Director, Aetna Life & Casualty, Hartford, Connecticut (Chesapeake Hall).

WEDNESDAY EVENING

6:30-7:30—President's Reception for Honor Guests (Old White Patio).

THURSDAY MORNING

August 24

8:30-5:00—Registration, Registration Lobby.

Opening Exercise

(Theater)

9:00—Call to Order—Joseph A. Smith, M. D., President, West Virginia State Medical Association.

Invocation—Joseph T. Skaggs, M.D.

Address of Welcome—Joseph A. Smith, M.D.

Introduction of David B. Gray, M.D., 1978 Program Committee Chairman, and other members of his Committee.

"The Thomas L. Harris Address"

James A. Reynolds, Executive Editor, Medical Economics, Oradell, New Jersey.

Subject: "The Outlook for Medicine in 1984 and Beyond."

First General Session

"Symposium on New Methods for Treatment of Common Disorders"

9:45-12:30

Moderator: Maurice A. Mufson, M.D.

Ruy V. Lourenco, M.D., Professor and Chairman, Department of Medicine, Abraham Lincoln School of Medicine, University of Illinois, Chicago. Subject: "Management of Chronic Pulmonary Disease."

John W. Eckstein, M.D., Dean, College of Medicine, The University of Iowa, Iowa City. Subject: "An Overview of Hypertension."

Gwendolyn R. Hogan, M.D., Professor of Pediatrics, and Director, Pediatric Neurology, University of Mississippi Medical Center, Jackson. Subject: "Seizures and Related Disorders."

Mary Lou L. Lewis, M.D., Clinical Professor of Medicine, Charleston Division, West Virginia University Medical Center, Charleston. Subject: "Newer Methods of Treatment in Renal Disease."

12:00—Recess for Lunch.

THURSDAY AFTERNOON

12:30—Luncheon Honoring Past Presidents of the West Virginia State Medical Association. John J. Mahood, M.D., *Presiding* (Tyler Room).

2:00—Resolutions Committee—Richard E. Flood, M.D., *Presiding* (Directors' Room).

THURSDAY EVENING

6:30—Cocktail Party. West Virginia University Alumni Association. Clark K. Sleeth, M.D., *In Charge* (West Virginia Room).

FRIDAY MORNING

August 25

Breakfast Meetings

7:30—West Virginia Academy of Ophthalmology and Otolaryngology. R. Lawrence Dunworth, M.D., *Presiding* (Washington Room).

7:30—Section on Internal Medicine. Harold Selinger, M.D., *Presiding* (Lee Room).

7:30—West Virginia Obstetrical and Gynecological Society. Samuel J. Bracken, M.D., *Presiding* (Tyler Room).

Individual Case Histories and General Discussion.

7:30—Section on Dermatology. Nazem Abraham, M. D., *Presiding* (Jackson Room).

Moderator: William A. Welton, M. D., Professor and Chairman of Dermatology, West Virginia University Medical Center, Morgantown, assisted by Staff Residents.

Presentation of Case Histories by Individual Members, Including Biopsies and Clinical Photographs.

7:30—Section on Surgery. Robert J. Reed III, M.D., *Presiding* (Buchanan Room).

Guest Speaker: Edward E. Mason, M.D., Iowa City, Iowa. Subject: "Pneumoperitoneum as Preparation for Giant Hernia Repair."

8:00—Section on Urology. James W. Lane, M.D., *Presiding* (Directors' Room).

Guest Speaker: Mary Lou L. Lewis, M.D., Charleston, West Virginia. Subject: "Hematuria and Proteinuria in Children."

8:30-5:00—Registration, Registration Lobby.

Second General Session

(Theater)

Moderator: David B. Gray, M.D.

9:30—David J. S. Hunter, M.D., Associate Professor, Department of Obstetrics and Gynecology, and Director of Fetal-Maternal Medicine, West Virginia University Medical Center, Morgantown. Subject: "High-Risk Pregnancy."

10:15—Edward E. Mason, M.D., Professor of Surgery, The University of Iowa, Iowa City. Subject: "Surgical Treatment of Obesity."

11:00—Coffee Break.

11:15—Irvin M. Sopher, M.D., Chief Medical Examiner, State of West Virginia, Charleston. Subject: "The Medical Examiner System of West Virginia."

12:00—Recess for Lunch.

FRIDAY AFTERNOON

12:00—Publication Committee. Stephen D. Ward, M.D., *Presiding* (Buchanan Room).

12:15—Cancer Committee. David B. Gray, M.D., *Presiding* (Washington Room).

12:30—West Virginia Medical Institute, Inc., Board of Trustees. Harry S. Weeks, Jr., M. D., *Presiding* (Directors' Room).

2:00—West Virginia Chapter, American College of Emergency Physicians. William E. Walker, M.D., *Presiding* (Pierce Room).

Guest Speakers: Irvin M. Sopher, M.D., Charleston. Subject: "Emergency Forensic Medicine."

Ronald D. Stewart, M.D., Medical Director, Emergency Department, Presbyterian University Hospital; and Assistant Professor of Medicine, University of Pittsburgh. Subject: "Pre-Hospital Care—*Quo Vadis*?"

2:00—Section on Orthopedic Surgery. Robert N. Clark, M. D., *Presiding* (Tyler Room).

Guest Speakers: John A. Cardea, M.D., Professor and Chairman, Division of Orthopedic Surgery, Medical College of Virginia, Richmond. Subjects: "Diagnosis of Infected Non-Union of the Tibia," and "The Floating Knee."

Robert Durning, M.D., West Virginia Medical Center, Morgantown. Subject: "A Look at Pathological Hip Fractures."

Peter Thrush, M.D., WVU Medical Center. Subject: "Psychological Aspects of Orthopedics."

2:00—West Virginia District Branch, American Psychiatric Association. Donald C. Carter, M.D., *Presiding* (Lee Room).

Guest Speaker: Philip J. Marco, M.D., Associate Professor of Psychiatry, University of Missouri School of Medicine, Columbia. Subject: "Suggestions for a Psychiatrist's Direct and Cross-Examination While on the Witness Stand."

2:00—West Virginia Chapter, American Academy of Pediatrics. Herbert H. Pomerance, M.D., *Presiding* (Fillmore Room).

Guest Speaker: Gwendolyn R. Hogan, M.D. Subject: "Newer Concepts, Etiology of Reye's Syndrome."

4:00—West Virginia Chapter, American Society of Internal Medicine. Richard G. Starr, M.D., *Presiding* (Jackson Room).

5:00—Committee on Nominations. William E. Gilmore, M.D., *Presiding* (Directors' Room).

FRIDAY EVENING

6:00—Cocktail Party. The University of Virginia Medical School Foundation. William C Morgan, M.D., *In Charge* (Chesapeake Bay).

6:30—Cocktail Party. West Virginia Chapter, Medical College of Virginia Alumni Association. Buford W. McNeer, M.D., *In Charge* (Old White Patio).

10:00—Dance Sponsored by Auxiliary to the West Virginia State Medical Association. Music by Don Boyd and his Orchestra. Hostess: Mrs. Richard D. Richmond, Raleigh County (Chesapeake Hall).

SATURDAY MORNING

August 26

7:30—West Virginia Association of Pathologists. Karl L. Klapproth, M.D., *Presiding* (Directors' Room).

8:00—West Virginia Radiological Society. Orlando F. Gabriele, M.D., *Presiding*. Scientific Session followed by Business Meeting (Tyler Room).

Guest Speaker: Reed P. Rice, M.D., Professor of Radiology and Chief, Section of Gastrointestinal Radiology, Duke University Medical Center, Durham, North Carolina. Subject: "The Radiologic Evaluation of the Acute Abdomen."

9:00-2:00—Registration, Registration Lobby.

Third General Session

(Theater)

Moderator: Robert D. Hess, M.D.

9:30—Karen A. Zupko, Director, Department of Practice Management, American Medical Association, Chicago. Subject: "Personnel: What You Need for Office Efficiency."

10:15—Coffee Break.

10:30—Ms. Zupko. Subject: "Patient Relationships: Communications, Information, Rapport."

SATURDAY AFTERNOON

12:00—West Virginia State Society of Anesthesiologists. William N. Walker, Jr., M. D., *Presiding* (Directors' Room).

Guest Speaker: Edward E. Mason, M.D., Iowa City, Iowa. Subject: "Pulmonary Considerations in Surgical Treatment of Obesity."

2:30—Second and Final Session of the House of Delegates. Joseph A. Smith, M. D., *Presiding* (Chesapeake Hall).

Invocation: Joe N. Jarrett, M.D.

Presidential Address: Joseph A. Smith, M.D., President, West Virginia State Medical Association.

Presentation of New Officers of Auxiliary to the West Virginia State Medical Association.

Presentation of Honor Guests.

Business Meeting.

Election of Officers.

Installation of Robert D. Hess, M.D., Clarksburg, as President of the West Virginia State Medical Association.

SATURDAY EVENING

6:30-7:30—Cocktail Party and Reception Honoring Officers of the West Virginia State Medical Association (Colonial Hall Terrace).

A WORD OF THANKS

The 1978 Program Committee, and the officers and members of the West Virginia State Medical Association, wish to acknowledge with sincere thanks grants received from the following Firms to help support the Scientific Program for this year's 111th Annual Meeting.

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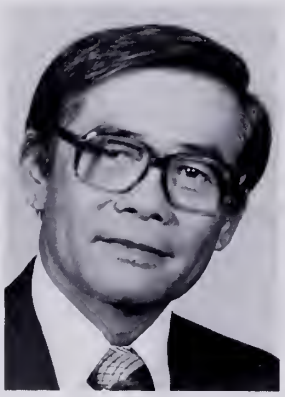
(The firms listed above are those which had allocated funds to the Scientific Program as this issue of *The Journal* went to press. Additional contributors will be listed in the Official Program to be distributed at the Greenbrier.)

1978 PROGRAM COMMITTEE

David B. Gray
Charleston
Chairman



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Robert D. Hess
Clarksburg

Barbara Jones
Morgantown

James T. Hughes
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Maurice A. Mufson
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DELEGATES AND ALTERNATES

BOONE (2)—Delegates, A. E. Glover and Harold H. Howell, Madison. Alternates, W. V. Wilkerson and George H. Cook, Whitesville.

BROOKE (2)—Delegates, James E. Wise, Follansbee; and W. T. Booher, Sr., Wellsburg. Alternate, Ralph McGraw, Follansbee.

CABELL (11)—Delegates, William J. Echols, Maurice A. Mufson, Gary G. Gilbert, Charles E. Turner, James P. Carey, George J. Hill, Jr., William L. Neal, Jack Leckie, Gilbert A. Ratcliff, M. Bruce Martin and Nazem Abraham, Huntington.

CENTRAL WEST VIRGINIA (4) — Delegates, Greenbrier Almond and Araceli V. Ganan, Buckhannon; Roger Paul Bennett, Upperglade; and Joseph B. Reed, Buckhannon. Alternates, Louis W. Groves, Jr., Richwood; John D. Jacobson, Summersville; I. Frank Hartman II, Buckhannon; and Clemente Diaz, Richwood.

EASTERN PANHANDLE (5)—Delegates, L. Walter Fix, Leo H. T. Bernstein and Jean P. Lucas, Martinsburg.

FAYETTE (3)—Delegates, Joe N. Jarrett, Ivan H. Bush, Jr., and W. P. Bittinger, Oak Hill. Alternates, A. R. Bautista and Chuan H. Lee, Montgomery; and Lewis A. Cook, Fayetteville.

GREENBRIER VALLEY (4)—Delegates, Romeo R. Ednacot, Robert K. Modlin and W. Dickson Moss III, Ronceverte; and Harvey A. Martin, White Sulphur Springs. Alternates, Houston B. Moore, William D. McClung, Robert G. Shirey and Eugene McClung, Lewisburg.

HANCOCK (4)—Delegates, Richard E. Flood and J. L. Thompson, Weirton. Alternates, David H. Williams, Ray S. Greco and Thomas J. Beynon, Weirton.

HARRISON (5)—Delegates, Julian D. Gasataya, Lumberport; M. V. Kalaycioglu, Shinnston; L. Dale Simmons, Reverdy H. Jones, Jr., and Charles S. Harrison, Clarksburg. Alternates, Victorino D. Chin, Bridgeport; Paul E. Gordon and C. B. Mendoza, Clarksburg; and Louis C. Palmer, Bridgeport.

KANAWHA (19)—Delegates, Jean P. Cavender, Charleston; Marshall J. Carper and William D. Crigger, South Charleston; Donald E. Farmer, Dominic J. Gaziano, Robert L. Ghiz, Alfred J. Magee, Pat A. Tuckwiller, John F. I. Zeedick, George R. Callender, Jr., W. Alva Deardorff, Carl B. Hall and Sherman E. Hatfield, Charleston; George W. Hogshead, Nitro; Ralph J. Holloway, South Charleston; and Tony C. Majestro, Jimmie Lee Mangus, John B. Markey and Joseph T. Skaggs, Charleston. Alternates, Enrique Aguilar, Montgomery; David Bachwitt, South Charleston; John H. Bergman, Charleston; R. S. Birckhead, Gauley Bridge; S. L. Bivens, Jr., Charleston; Donald E. Cunningham, St. Albans; George V. Hamrick, Echols A. Hansbarger, Jr., and John M. Hartman, Charleston; Edward Jackson, St. Albans; William C. Revercomb, Charleston; Carl J. Roncaglione, South Charleston; David A. Santrock, Narinder N. Sehgal and Samuel A. Strickland, Charleston.

LOGAN (4)—Delegates, Abelardo A. Pelaez, Logan; Jorge J. San Pedro and Thomas P. Long, Man; and Pravin M. Patel, Logan. Alternates, Carlos F. DeLara, Shirish B. Patel, I. M. Kruger and Robert K. Scott, Logan.

MARION (4)—Delegates, William L. Mossburg, John C. Turner, Charles E. Haislip, Joseph T. Mallamo and Frank W. Mallamo, Fairmont. Alternates, William T. Lawson, Grace M. Reynolds, Carter F. Cort, Chi Meen Lee and John A. Rizzo, Fairmont.

MARSHALL (3)—Delegates, Erol Bastug, M. F. Anwar and Kenneth J. Allen, Glen Dale. Alternate, David E. Yoho, Glen Dale.

MASON (2)—Delegates, Aarom Boonsue and Richard L. Slack, Pt. Pleasant. Alternate, Ismael O. Jamora, Pt. Pleasant.

McDOWELL (4)—Delegates, Stephen Mamick, Arthur Allen Carr, Muthusami Kuppusami and John S. Cook, Welch. Alternates, Ray E. Burger, Welch; Richard O. Gale, Gary; A. J. Villani and Bernard M. Swope, Welch.

MERCER (7)—Delegates, Lawrence J. Pace and Frank J. Holroyd, Princeton; Sam Milchin, Bluefield, Virginia; Edward M. Spencer, John J. Mahood, P. R. Higginbotham and Peter M. Schwab, Bluefield.

MINGO (2)—Delegates, Edward B. Headley, Delbarton; and Arthur E. Levy, Williamson. Alternates, Andrew H. Henderson, Turkey Creek, Kentucky; and Russell A. Salton, Williamson.

MONONGALIA (13)—Delegates, John H. Wolf, Jr., David Z. Morgan, Roger E. King, Ludwig Gutmann, Ralph W. Ryan, Lawrance S. Miller, William A. Neal, George A. Curry, Richard S. Kerr, Margaret I. Stemple, Joe Wesley Rhudy, J. Hugh Wiley and Barbara Jones, Morgantown. Alternates, Philip M. Sprinkle, Robert L. Smith, K. Douglas Bowers, Jr., R. F. Krause, Herbert E. Warden, N. LeRoy Lapp, Joel Allen V, Charles E. Andrews, H. Summers Harrison, Robert H. Waldman, J. W. Kessel, Isaiah A. Wiles and Clark K. Sleeth, Morgantown.

OHIO (10)—Delegates, Thomas O. Dickey, Robert U. Drinkard, John P. Griffith, Jr., Edward S. Phillips, Robert J. Reed III, Jess S. Renedo, Thomas

L. Thomas, Stephen D. Ward, Harry S. Weeks, Jr., Robert R. Weiler, Wheeling. Alternates, William R. Barton, N. K. Joseph, Frank J. Keefer, D. Verne McConnell, W. E. McNamara, David W. Palmer, B. P. Papadimitriou, Martin D. Reiter, Howard B. Sauder, Edward C. Voss, Jr., Wheeling.

PARKERSBURG ACADEMY (8) — Delegates, Bruce H. Pierson, Jr., Lyle D. Vincent, Francis C. Huber, Jr., Robert C. Cowan, Jr., and Charles W. Thacker, Parkersburg.

POTOMAC VALLEY (3)—Delegates, David R. Chapman, Carl A. Liebig and Harry F. Coffman, Keyser.

PRESTON (2)—Delegates, Del Roy R. Davis and Donald P. Brown, Kingwood. Alternates, John W. Trenton, Kingwood; and Thomas A. Haymond, Masontown.

RALEIGH (7)—Delegates, John M. Daniel, William D. McLean, Eugene Warvariv, John A. Hedrick, Guy F. Hollifield and R. C. Jereza, Beckley. Alternates, Lamberto C. Maramba, T. J. Ma-Luf, Richard D. Richmond, Nicholas D. Zambos, W. H. Rardin and Joseph A. Maiolo, Beckley.

SUMMERS (2)—Delegates, Buford W. McNeer and Jack D. Woodrum, Hinton. Alternates, E. L. Jimenez and Chandra P. Sharma, Hinton.

TYGART'S VALLEY (5)—Delegates, Vernon E. Duckwall and H. L. Jellinek, Elkins; A. Kyle Bush, Philippi; and Samuel M. Santibanez, Grafton. Alternates, J. Martin Nissley, Philippi; and Robert R. Rector, Elkins.

WETZEL (2)—Delegates, Allen M. Dyer, Jr., Pine Grove; and Rosario D. Suyao, New Martinsville. Alternates, Donald A. Blum and Lemoyne Coffield, New Martinsville.

WYOMING (2)—Delegates, Ross E. Newman and Frank J. Zsoldos, Mullens. Alternate, George F. Fordham, Mullens.

Reception Committee

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Official Program

AUXILIARY

to the

West Virginia State Medical Association

54th Annual Meeting

THE GREENBRIER
White Sulphur Springs

August 23-26, 1978

WEDNESDAY AFTERNOON

August 23

2:30—First Session of the House of Delegates, West Virginia State Medical Association (Chesapeake Hall).

Address by Tom E. Nesbitt, M. D., President, American Medical Association.

4:00—Pre-Convention Board Meeting, Mrs. Joseph T. Mallamo, President, presiding (Fillmore-Van Buren Rooms).

WEDNESDAY EVENING

6:30-7:30—President's Reception for Honored Guests (Old White Patio).

THURSDAY MORNING

August 24

9:00—Formal Opening of the 111th Annual Meeting of the West Virginia State Medical Association (Theater).

"The Thomas L. Harris Address"

Mr. James A. Reynolds, Oradell, New Jersey, Executive Editor, Medical Economics.

(Auxiliary Members are Invited to Attend.)

10:00—Formal Opening of the Convention, Mrs. Joseph T. Mallamo, President, presiding (Fillmore-Van Buren Rooms).

Invocation, Pledge of Loyalty, and Pledge to Flag—Mrs. Harry S. Weeks, Jr.

Introduction of Honor Guests.

Presentation of Joseph A. Smith, M. D., President, West Virginia State Medical Association.

Introduction of Convention Co-Chairmen—Mrs. Harry C. Fleming and Mrs. Kenneth D. Bailey.

Roll Call of Delegates—Mrs. Gary G. Gilbert.

Convention Rules of Order—Mrs. William T. Lawson.

Treasurer's Report—Mrs. Charles S. Harrison.

In Memoriam—Mrs. A. G. Capinpin.

Credentials and Registration—Mrs. Charles C. Weise.

Keynote Address—Mrs. Manuel A. Bergnes, President, American Medical Association Auxiliary.

Recommendations from Preconvention Board Meeting—Mrs. M. Bruce Martin.

New Business and Announcements.

Report of the Nominating Committee, First Reading—Mrs. J. L. Mangus.

Election of 1979 Nominating Committee.

Reports of Officers and Standing Committee Chairmen (These will not be read, but are published in the Annual Reports' Book).

Presentation of Regional Directors:

Eastern Region—Mrs. Richard S. Kerr.

Northern Region—Mrs. George Naymick.

Western Region—Mrs. Charles E. Turner.

Southern Region—Mrs. E. M. Spencer.

Central Region—Mrs. Robert E. Sams.

Recess.

THURSDAY AFTERNOON

2:00—Bridge (Trellis Lobby). Host, Marion County, Mrs. William T. Lawson, Chairman.

FRIDAY MORNING

August 25

8:00—Past Presidents' Breakfast, Mrs. J. L. Mangus, Immediate Past President, presiding (Virginia Room).

9:30—Second General Session—Mrs. Joseph T. Mallamo, President, presiding (Fillmore-Van Buren Rooms).

Introduction of Honor Guests.

Address—George E. Pickett, M. D., Director, West Virginia Department of Health.

Roll Call of Delegates—Mrs. Gary G. Gilbert.

Report of Reading Committee.

Report of Convention Committees:

Finance—Mrs. J. Dennis Kugel.

Credentials and Registration — Mrs. Charles C. Weise.

Press and Publicity — Mrs. Miroslav Kovacevich.

Presentation of AMA-ERF Awards—Mrs. Charles E. Andrews, State Chairman.

Address—Mrs. M. Bruce Martin, President, Auxiliary to the Southern Medical Association.

Unfinished Business.

Report of the 1978 Nominating Committee, Second Reading—Mrs. J. L. Mangus.

Election of Officers.

Installation of Officers — Mrs. Manuel A. Bergnes, President, American Medical Association Auxiliary.

Presentation of President's Pin and Gavel—Mrs. Joseph T. Mallamo.

Presentation of Past President's Pin—Mrs. J. L. Mangus.

Inaugural Address—Mrs. Robert J. Reed III.

Announcements.

Adjournment.

FRIDAY AFTERNOON

2:00—Tennis Tournament — Host, Ohio County, Mrs. Stephen D. Ward, Chairman.

Golf may be played (for tournament) either Thursday or Friday.

FRIDAY EVENING

10:00-1:00—Dance, Music by Don Boyd and his Orchestra.

"Little or No Talent Show" during intermission. Host: Raleigh County, Mrs. Richard D. Richmond, Chairman (Chesapeake Hall).

SATURDAY MORNING

August 26

10:00—Postconvention Board Meeting—Mrs. Robert J. Reed III, President, presiding (Fillmore-Van Buren Rooms).

SATURDAY AFTERNOON

2:00—Second and Final Session of the House of Delegates, West Virginia State Medical Association (Chesapeake Hall).

Presidential Address—Joseph A. Smith, M.D.

Installation of Robert D. Hess, M. D., as 1978-79 President of the West Virginia State Medical Association.

(Auxiliary Members are Invited to Attend.)

SATURDAY EVENING

6:30-7:30—Cocktail Party and Reception Honoring the Officers of the West Virginia State Medical Association and its Auxiliary (Colonial Hall Terrace).

SCIENTIFIC EXHIBITS

AMERICAN HEART ASSOCIATION, WEST VIRGINIA AFFILIATE

"ADVANCED CARDIAC LIFE SUPPORT." Slide presentations, demonstrations, and registrant participation in selected parts of the Advanced Life Support course of the American Heart Association. This course was developed in 1975 to present a summary and review of the definitive treatment of patients suffering a cardiac arrest. Stations that will be available include endoctrachael intubation, defibrillation, and basic life support.

Bernadette R. Page, M. D., National Faculty, AHA; Jack R. Page, M. D., National Faculty, AHA; Anita Lourin, R.R.T.; Keith Boyd, Basic Instructor-Trainer, and Steve Parrish, Physio-Control Representative, all West Virginia Affiliate Faculty.

COMMITTEE FOR VENEREAL DISEASE EDUCATION, WEST VIRGINIA UNIVERSITY MEDICAL CENTER

"5 PEOPLE A MINUTE DON'T . . . AVOID VD." The Committee for Venereal Disease Education is composed of medical, pharmacy and nursing students from WVU Medical Center. These students have presented VD education programs to more than 6,000 junior high and high school students in north-central West Virginia. In addition, the committee has worked in conjunction with the West Virginia Department of Health in the production of six television public service announcements for use each February for "State VD Awareness Month." The committee's mobile VD information center is used to help educate the public about the signs, symptoms and treatment of the sexually-transmittible diseases.

Debra Gouge, Junior Nursing Student, Project Director; James Comerci and Jeff Kugel, committee members.

JUDITH G. GREENWOOD, PH.D., RESEARCH ASSOCIATE, DEPARTMENT OF COMMUNITY MEDICINE

Charleston Division, West Virginia University Medical Center

"EPIDEMIOLOGY OF PHYSICAL REHABILITATION NEEDS." Case-load estimates are presented based on literature review of conditions that could benefit from physical rehabilitation. These estimates are compared with the case loads currently receiving services from the West Virginia Division of Vocational Rehabilitation, West Virginia Department of Welfare, and the state Workmen's Compensation Fund. Data on case loads, service costs, and manpower requirements from rehabilitation facilities in other states are summarized. Analysis of interviews with patients discharged from WVU Hospital and Charleston Area Medical Center/General Division with selected diagnoses and without referral to the Division of Vocational Rehabilitation show to what extent rehabilitation has been achieved without special services and indicate certain gaps in care and service delivery in the state. (This study was undertaken as the result of a resolution passed during the 1977 Annual Meeting of the State Medical Association directing the Association, with the help of allied groups, to document the need for a Physical Rehabilitation Center in the state.)

THE MYERS CLINIC—BROADDUS HOSPITAL

"PHEOCHROMOCYTOMA." This exhibit is an overview of pheochromocytoma, with the case presentation, gross and photomicrographs, history, diagnosis, etiology, etc.

Fulvio R. Franyutti, M. D., Director of Laboratories, and J. Richard Crawford, RBP, Director of Photography.

NATIONWIDE INSURANCE—MEDICARE

"MEDICARE INFORMATION." Nationwide invites you to stop by and discuss the expanded list of 350 procedure codes recently issued to aid your billing of Medicare claims. Obtain an extra copy if needed.

Don F. Harper, District Medicare Manager; Randy Swecker, District Medicare Manager; J. A. Cuppy, Field Service Manager, and H. F. Hughes, Field Operations Manager.

UNITED STATES AIR FORCE

"U. S. AIR FORCE HEALTH PROFESSIONS RECRUITING." Opportunities for physicians to practice their professions with the U. S. Air Force Medical Corps. If you're a physician who at one time or another has considered a change, then take a look at the Air Force facilities and programs. We in the Air Force believe ours is one of the finest health-care programs in the nation, and that it offers many unusual professional as well as personal opportunities. Additionally, our health-care team is composed of individuals dedicated to the ideals which made America great, and to the continuation of 200 years of freedom. In short, we feel it is a great way of life and that it offers many advantages to the modern physician.

G. H. Hall, Colonel, USAF, BSC; Ted Williams, Captain, USAF, MSC, and Larry W. Redmond, MSgt, USAF.

UNITED STATES ARMY

"U. S. ARMY MEDICAL CORPS." U. S. Army Medical Corps counselors will be available to discuss opportunities for medical scholarships, graduate

medical education, and various clinical, academic and research opportunities.

Major Bob Sellards and Captain Tom Woltman, AMEDD Personnel Counselors.

OFFICE OF CONTINUING EDUCATION, WEST VIRGINIA UNIVERSITY SCHOOL OF MEDICINE

"CONTINUING MEDICAL EDUCATION." Toll-free Patient Care Telephone Consultation service is available from the West Virginia University School of Medicine as a continuing medical education service. The exhibit demonstrates the use of the "MED-LINE" service of the National Library of Medicine in securing medical literature through "MED-LINE" search.

Robert L. Smith, M. D., Assistant Dean, Continuing Medical Education, and Robert L. Murphy, WVU Medical Center Librarian.

WEST VIRGINIA DEPARTMENT OF WELFARE—MEDICAID PROGRAM

MEDICAID IN WEST VIRGINIA." The exhibit will display the West Virginia Medicaid Program. The Department of Welfare is the single state agency responsible for administration of the Title XIX (Medicaid) program financed by state and federal funds. The impact of this federal-state partnership in health on citizens of West Virginia will be illustrated. Eligibility requirements, people served, and program benefits will be highlighted. Featured also will be the costs of providing coverage for this broad scope of necessary medical services.

J. L. Mangus, M. D., Medical Director, Division of Medical Care; C. Jean Cebula, Nurse Coordinator, Division of Medical Care, and Emily Humphreys, R. N., Division of Medical Care.

DIVISION OF VITAL STATISTICS, WEST VIRGINIA DEPARTMENT OF HEALTH

"LIFE AND DEATH ON A CALCULATOR." Do you wonder what happens to the birth certificate after you sign it? Do you wonder how the cause of death you listed makes its way into local, state and national health statistics? Do you have any questions about the recent changes in life and death reporting—about the revised certificates, the direct reporting system, of the soon-to-be-installed I.C.D.-9? If you were born in West Virginia, would you like to check on whether your birth certificate or that of any of your family born in West Virginia is on file? If your answer is "yes" to any of these questions, then come see our exhibit. If you haven't answered "yes," come anyway—we would love to meet you!

Joseph D. Carney, State Registrar.

ANNUAL REPORTS

Committee on Medical Economics

As one of those charged by the Association with overseeing activities of the various subcommittees of the Committee on Medical Economics, we are in a position which might best be described as awkward, if in no other way. We now are seeing more major changes evolving in the area of medical economics than ever before —with little or no input into such policy and other changes. We are, in fact, operating under a self-imposed gag because of the threat of Federal Trade Commission action against medical societies.

What we are saying is that there is considerable pressure — economically, politically and socially — to change the practice of medicine. Politically, we frequently see unstructured, harsh criticism of the profession. Socially, it has been pointed out by others that since the American public no longer wallows in ethnic slurs and racial hatred, it appears to have substituted the professions — all professions — as objects of negative bias. Economically, we are aware of the devastating effect of years of inflation and public reactions to control it.

What information is available for our defense? Are doctors or any group to be denied the right to assemble and discuss common problems? There are days when one gets that impression. Certainly, there are elements in our society that would deny us our basic rights. Two years ago, I polled this Committee to see if interest existed for looking at viable alternatives to our present modus operandi. The reaction was overwhelmingly negative. I personally feel that we should stay informed of our options whether or not we agree that they are necessary or wanted. Guilds, unions and other conventions have served organized groups in the past and are of more than passing interest to some.

There is substantial effort being mounted by the Federal government to enroll the public in prepaid health plans—HMOs. One such organization has been formed this year by an IPI (Individual Practice Association) established by the Ohio County Foundation For Medical Care. This organization deserves your attention. Current physician membership is 200. The open panel approach to prepaid coverage seems to be the only acceptable option for the private practitioner today.

With the exception of the Rehabilitation Subcommittee, and some constructive efforts in the area of Workmen's Compensation, the atmosphere is not conducive at this writing to a satisfactory report by the overall Committee on Medical Economics.

The United Mine Workers of America strike and change in funding for health services are not news, but they are going to affect this state for years to come. Incidentally, the subcommittee in this area is probably of little value now.

The state agencies — Health, Welfare and Compensation — do not reflect adequate concern for the profession. Of this group, Compensation has taken the prize for difficulties with the medical profession, labor, management and the legislature. Our meeting of June 7 with the Commissioner culminated 18 months of dissatisfaction and we shall take a "wait and see" attitude as to its results.

Of current interest, too, is legislative thinking toward restructuring Blue Shield boards to provide non-physician control. This seems to be popular with those trying to limit health care expenditures. Apparently they think there is a correlation between inflation and physician representation on Blue Shield boards. The reverse is true! Blue Shield plans have *not* been known for liberal allowances, and many physicians in this state have ceased being participating physicians in the plans.

If the past is prologue, then we are in for a rocky time ahead. If not, relax and enjoy life as you know it. As a seasoned observer, my one admonition is to get with it. Things are worse, and have been for some time.

Respectfully submitted,
Harry S. Weeks, Jr., M. D.
Chairman

May 23, 1978

Cancer Committee

This is a report from the Cancer Committee of the West Virginia State Medical Association. The Cancer Committee has held two meetings in the past 12 months, the first on August 25, 1977, and the second on January 29, 1978. The report from the Division of Cancer Control, State Department of Health, was presented by Doctor William L. Cooke, Director. Discussion then

followed on steps the Committee might recommend to improve reporting by the hospitals to the Central Cancer Registry.

The activities of the American Cancer Society, West Virginia Division, were reported by Mr. Bob Bradford of Charleston, Executive Vice President. He reported that as a result of the notice published in the *West Virginia Medical Journal*, he received requests from 257 physicians in the state to purchase a copy of the book, *Clinical Oncology*, which is published and distributed under the auspices of the American Cancer Society. Mr. Bradford also brought up the fact that the state of West Virginia does not have any legislation relating to cancer quackery. It was felt that this should be relayed to the Council of the State Medical Association and an effort be made to see that such a bill is placed in the state Legislature for consideration. The American Cancer Society, West Virginia Division, also supported the training of two more enterostomal therapists in the state.

At the meeting on January 29, 1978, which was held in conjunction with the State Medical Association's Eleventh Mid-Winter Clinical Conference, Doctor Cooke presented a report from the Division of Cancer Control and stated that it would probably be phased out along with the Central Cancer Registry and a new approach to the responsibilities of the cancer patient be formulated by the State Health Department.

A discussion was held concerning increasing the public information on laetrile to point out that it is an unproven method for the treatment of cancer and has never shown any benefit in carefully controlled studies. It was also pointed out that there were three or four bills before the state Legislature this year to legalize the use of laetrile in West Virginia. It was the opinion of the Committee that there should be medical represention for the professional hearing and also for the open public hearing in opposition to these bills. (Note: The 1978 Legislature enacted no laetrile measure.)

The American College of Surgeons, West Virginia Chapter, Cancer Liaison Committee is supporting the expansion of Tumor Registrars in all of the hospitals, and is working toward having a physician on each active staff designated as the consultant for the Tumor Registry in order to help the Registrars carry out their work.

In summary, the Committee moved that the state Legislature be as fully informed as possible on the laetrile issues:

(1) That it is an unproven method; (2) That it may interfere with the use of proven effective methods of cancer treatment; (3) There is increasing evidence of toxicity due to cyanide poisoning from the taking of laetrile; and (4) The danger of opening the door for all types of cancer quackery and cancer quackery clinics is a real one.

Respectfully submitted,
David B. Gray, M. D.
Chairman

May 19, 1978

Committee on Medical Aspects of Sports

The prime function of the Committee this year has been to delineate specific responsibilities of a team physician. The following list is offered as a guide to those physicians serving as such. It is recommended that it be used in effecting a written agreement with school officials. The list can be modified as deemed desirable by the parties involved prior to consummation of a formal agreement.

The team physician:

1. Shall conduct the pre-participation physical exam himself or be satisfied that one has been done by a licensed physician, having a written report to this effect.
2. Shall assure the availability of adequate, standard protective equipment and its proper fitting and use. He also shall be responsible for insuring that special protective devices are utilized where indicated in individual cases.
3. Shall be present at home football games, or provide adequate coverage in his absence. He shall use his discretion concerning his presence at other athletic events.
4. Shall be available during heavy contact practice sessions, or provide adequate coverage.
5. Shall be responsible for emergency care of injuries incurred during scheduled games or practice sessions.
6. Shall provide definitive care of such injuries within his professional capabilities and shall provide for proper referral otherwise.
7. Shall provide for proper postinjury/postoperative rehabilitation.
8. Shall determine if and when a previously injured athlete is capable of resuming participation. If definitive care has been provided by another physician, the team

physician shall obtain a full report and written release for return to activity from the treating physician.

9. Shall take precautions to be informed of any significant change in an athlete's general health. Parents, athletes and coaches share the responsibility of providing such information. In cases where athletes are treated by other physicians, the team physician should disallow participation until a written release allowing such is received from the treating physician.
10. Shall inform athletes and parents concerning the extent and nature of any injury and possible sequela.
11. Shall assume absolute authority concerning participation in all cases wherein the physical well-being of an athlete may be jeopardized.

Team physicians are *not* to be held responsible for the adequacy or relative safety of playing surfaces, nor are they responsible for providing equipment or supplies.

The Committee strongly endorses the athletic training curriculum at the college level and recommends the placement of Certified Athletic Trainers in our school system.

Respectfully submitted,
K. Douglas Bowers, Jr., M. D.
Chairman

June 30, 1978

Insurance Committee

It has been 30 years since the West Virginia State Medical Association Group Insurance Program was established. This makes our program one of the oldest in the United States, and something we all should be proud of as members. Many other state and national associations have used our program to design and implement plans of their own.

The success of our Group Program has stemmed from efficient administration which has resulted in establishment of eight separate Plans. The fact that these Plans are administered in the state and all functions, including the processing of applications, billing and collecting premiums, and the processing and payment of claims, are all handled by competent personnel, has added to the proficiency of the Group Program. There is an "on call" service representative who travels the entire state and is available for consultation, coordination of coverage, and to assist when necessary in the filing of claims.

In order for our Group Insurance Program to remain sound, it is important to continue our active support of all plans by continuing to enroll and for the administrator to maintain its high quality of professional service.

Because of the various coverages offered at low group rates and the flexibility within each plan, the following is an up-to-date review of the Plans which compose the West Virginia State Medical Association Program of Group Insurance:

1. Long-Term Disability Income Protection pays up to $500 a *week*. There are three plans to choose from and you can individualize these plans with a wide variety of self-insured waiting periods.
2. Office Overhead Expense—If you are unable to work due to a disabling accident or illness, this plan offers up to $3,500 a month to pay the regular operating cost including rent, utilities, depreciation, employees' salaries and other normal fixed overhead costs. An important feature of this plan is that your premiums are tax deductible.
3. Family Major Hospital Insurance—Serious illness or a severe accident often means weeks, even months of hospitalization and can be financially disastrous. The Family Major Hospital plan is designed to help cover these major hospital expenses up to $30,000, including room and board of $60 a day.
4. Hospital Money Plan—This plan offers a schedule of benefits up to $100 a day for each day of hospitalization for a member and spouse. Dependent children may be insured up to $50 a day. This plan is designed to provide the "over and above" expenses that inevitably attend today's hospital confinement.
5. Term Life Insurance—This plan offers up to $50,000 in units of $10,000 for members. There is an optional coverage available for spouse and children in lesser amounts.
6. Accidental Death and Dismemberment—You can purchase up to $100,000 of Accidental Death and Dismemberment insurance and your coverage is effective 24 hours a day, 365 days a year, at home or away, on or off the job, and anywhere in the world. You are fully protected as a passenger for regular commercial airline travel.

7. Coordinated Investment Service—Specifically designed for HR-10, this plan offers mutual funds, fixed or variable annuities, and split funds.
8. Group Professional Liability Insurance—The Professional Malpractice Package Plan offers up to $1,000,000 protection, including umbrella excess liability limits over auto, office, and personal coverages.

In summary, our 30 years of continuned support of the West Virginia State Medical Association Group Insurance Program has enabled our members to select from a variety of well designed plans that suit their insurance needs. With the continued professional administration of the membership, there is no doubt that our Group Insurance Program will continue to be a success in offering insurance protection at group rates for at least another 30 years.

Professional Liability Program

The Professional Liability Program sponsored by the Association and written by the Aetna Life and Casualty Company is now in its sixth year. This year proved to be a "good news" year. For the first time, there were no substantial increases in premium. In fact, the overall premiums decreased by about one and one half per cent. A dividend amounting to $84,398 was also returned to the physicians participating in the program. This was due primarily to a savings in the administrative cost to the company and to a moderation of claims in frequency and severity over the last few years.

In the first three months of 1978, there were 124 pending malpractice cases in the state. The total dollars reserved by the company to handle these cases amounted to $2,002,540—an average of $16,149 per case.

One aspect affecting insurance costs, over which there can be some control, is an effective loss control and education program. The program's goal is to assist physicians in recognizing and avoiding situations that can lead to claims and suits, and that also can hinder the defense of cases. Involved is the analytical study of West Virginia cases to determine their cause. Insights gained through the study are passed on to the physicians. The Aetna Account Supervisor is available to address local societies and specialty groups insured in the program to keep them up to date with current developments.

Another important loss control and education function is conducted by the District Claim Review Panels. Five panels exist in the state. At the beginning of 1978, the panels had reviewed 28 cases since the inception of the program. Twelve of the cases reviewed had been resolved by the Claim Department—five of these without any payment. Of the remaining seven cases, $120,028 less was paid than had been expected prior to the review by the panels. This represents a substantial savings and, to a large part, is attributable to the impact of the panel members. The doctors and Aetna are learning from each other about the problems unique to medical malpractice in West Virginia.

The program, at present, is succeeding in most areas. Additional improvement can be hoped for with continued emphasis of the loss control and educational aspects of the program.

Respectfully submitted,

Lyle D. Vincent, M. D.
Chairman
John T. Chambers, M. D.
David V. Cole, M. D.
R. U. Drinkard, M. D.
L. Walter Fix, M. D.
F. Perry Greene, Jr., M. D.
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June 15, 1978

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OFFICERS OF COMPONENT SOCIETIES

Society	President		Secretary		Meetings
Boone	W. V. Wilkersan	Whitesville	Harold H. Hawell	Madison	3rd Wed.
Brooke	Ragelia L. Velarde	Fallansbee	James E. Wise	Follansbee	
Cabell	William J. Echals	Huntingtan	James R. Cook	Huntington	2nd Thurs.
Central West Virginia	Rager Paul Bennett	Upperglade	Joseph B. Reed	Buckhannon	As Sched.
Eastern Panhandle	Harry B. Scott	Martinsburg	Harvey D. Reisenweber	Martinsburg	2nd Wed.
Fayette	Chuan H. Lee	Mantgamery	Jae N. Jarrett	Oak Hill	1st Wed.
Greenbrier Valley	Romea R. Ednacot	Ranceverte	Rabert K. Modlin	Ronceverte	2nd Wed.
Hancock	Ray S. Greca	Weirtan	Carlos L. Vasquez	Weirton	3rd Tues.
Harrison	Walter E. Williamsan	Bridgeport	Lauis C. Palmer	Bridgeport	1st Thurs.
Kanawha	Jean P. Cavender	Charlestan	Marshall J. Carper	Sa. Charleston	2nd Tues.
Logan	Carlas F. DeLara	Logan	Abelarda A. Pelaez	Logan	2nd Wed.
Marion	Jaseph D. Ramina	Fairmant	John A. Rizzo	Fairmont	Last Tues.
Marshall	David E. Yaho	Glen Dale	Erol Bastug	Glen Dale	1st Tues.
Mason	Ismael O. Jamora	Pt. Pleasant	Richard L. Slack	Pt. Pleasant	4th Tues.
McDowell	Stephen Mamick	Welch	M. Kuppusami	Welch	2nd Wed.
Mercer	Rabert W. Neilsan	Bluefield	David F. Bell, Jr.	Bluefield	3rd Mon.
Mingo	Andrew H. Henderson	Williamson	Edward B. Headley	Delbartan	2nd Wed.
Monongalia	H. Summers Harrison	Margantawn	Barbara Jones	Morgantown	1st Tues.
Ohio	Jess S. Reneda	Wheeling	Thomas E. Chvasta	Wheeling	4th Tues.
Parkersburg Academy	R. C. Cawan, Jr.	Parkersburg	Charles W. Thacker	Parkersburg	1st Thurs.
Potamac Valley	Dewey F. Bensenhaver	Petersburg	David R. Chapman	Keyser	2nd Wed.
Preston	Thomas A. Haymond	Masantown	C. Y. Moser	Kingwoad	4th Thurs.
Raleigh	Kwan H. Lee	Beckley	Praspero B. Gogo	Beckley	3rd Thurs.
Summers	E. L. Jimenez	Hinton	Chandra P. Sharma	Hinton	3rd Mon.
Tygart's Valley	J. Marlin Nissley	Philippi	A. Kyle Bush	Philippi	3rd Thurs.
Wetzel	Lemoyne Caffield	New Martinsville	Chas. P. Watson	New Martinsville	Monthly
Wyoming	Frank J. Zsaldos	Mullens	Geargе F. Fardham	Mullens	Quarterly

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Robert E. O'Connor, M.D.
Moseley H. Winkler, M.D.
Samuel A. Strickland, M.D.

E.E.N.T.
John B. Haley, M.D.
John A. B. Holt, M.D.

OTOLARYNGOLOGY
Romeo Y. Lim, M.D.
Fred F. Holt, M.D.

OTOLOGY
William C Morgan, M.D.

RETINAL SURGERY
OPHTHALMIC PLASTIC SURGERY
FLUORESCEIN ANGIOGRAPHY
ARGON LASER PHOTOCOAGULATION
STRONTIUM 90 BETA IRRADIATION
ORTHOPTICS

HEAD AND NECK SURGERY
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M. E. Nugent, M. D.
R. V. Pangilinan, M. D.

Ear, Nose & Throat:
W. A. Tiu, M. D.
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Orthopedic Surgery:
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R. S. Glass, M. D.

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A. Athari, M. D.
J. W. Campbell, M. D.

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Dermatology:
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Psychiatry:
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David Hill, M. D.
David H. Smith, M. D.

Neurology:
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H. L. Kettler, M. D.

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WVU Medical Center
—News—

Compiled from material furnished by Mrs. Mary Ellin Wylie, Director, Medical Center News and Information Services, Morgantown, W. Va.

Epidural Anesthesia Offers Comfort in Childbirth

Proponents of "natural" childbirth have long opposed the use of drugs during labor, maintaining that they leave the mother incapable of participation and actually may slow down or stop contractions.

Their strongest argument has been against the use of general anesthesia during the birth process itself. They charge that the inhalation of gas such as ether deprives the mother of the joy of seeing her baby born, endangers the infant, who may be physically depressed at birth, and is an actual hazard to the mother herself.

On the other hand, many physicians have been unwilling to return women to the "bite the bullet" days of their grandmothers. Great pain, they say, is not only pointless, it weakens.

The newer approach to pain relief with its options and flexibility solves this all or nothing at all dilemma, according to Dr. Roland Kennedy, Professor of Anesthesia in the West Virginia University School of Medicine and Director of Obstetrical Anesthesia at University Hospital.

"With epidural anesthesia, the mother can have full conscious participation in labor and delivery," Doctor Kennedy said. "She can be made comfortable without fear of harming the baby. She can move around in bed, which is more comfortable for her than if she were immobilized. The amount of anesthesia can be adjusted as her needs develop."

Epidural anesthesia, Doctor Kennedy explained, is injected around the dura or membrane covering the spinal cord. It lends itself to continuous and/or flexible anesthesia because a small catheter or tube is left in the injection site where more anesthesia can be given as it is needed.

The anesthesia is regional, he said, and its target area is a band around the lower abdomen. It differs from the spinal or saddle block in that it relieves pain with less effect on the ability of the patient to move the lower part of her body.

But its primary advantage is that with proper administration it has no effects—not even short term ones—on the baby.

"Sophisticated neurological tests have shown that the preferred local anesthesias we use do not affect the child," Doctor Kennedy said, explaining that both a short acting and a longer acting anesthesia were used.

All of the advantages of natural childbirth including the presence of the husband in the delivery room can be realized with the use of epidural anesthesia, Doctor Kennedy noted.

Staff Physician Combines Clinical Care, Research

Dr. Barbara Farrell is a West Virginia University Neurologist who combines clinical care for seizure patients with basic research on the drugs used to treat them.

In her clinical work, she sees hospital and clinic patients regularly and serves as a consultant on other cases.

In the laboratory, she's engaged in research at the basic level, trying to gain a better understanding of how information moves electrically and chemically from one nerve cell to another and how various drugs affect that movement.

Her laboratory work has won support from the National Institute of Health with a postdoctoral fellowship. Doctor Farrell will spend two years, under the supervision of Dr. Albert J. Azzaro in the WVU Departments of Neurology and Pharmacology, in research training in the areas of neurochemistry and neuropharmacology.

Doctor Azzaro and Neurology Chairman Dr. Ludwig Gutmann noted that the award is prestigious and highly competitive.

"Only a limited number are granted each year," Doctor Gutmann said.

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Third-Party News, Views and Program Concerns

Progress Seen In Curbing Hospital Cost Rise

Doctors and hospitals are beginning to get a handle on the rising cost of hospital care, Paul W. Earle, executive director of the voluntary effort of organized medicine and hospitals to curb costs, declared.

Speaking at a recent national meeting of the Health Section of the Public Relations Society of America at Chicago, Earle said the professions are achieving their goal of reducing by two per cent each year the percentage of cost rise.

In 1976, hospital costs increased by 19.7 per cent, Earle said. In 1977, the rate of increase was pared to 15.6 per cent. And for the first quarter of 1978, the rate of increase was only about 13 per cent.

"Hospitals and doctors are tightening up. There's no doubt about it," Earle declared.

There have been more mergers, more sharing of services, a slowing of expanding hospital personnel. And the average length of stay—7.4 days in recent years—has been reduced to 7.2. In national terms, this represents a substantial saving.

The voluntary cost containing effort is a joint endeavor of the American Medical Association, American Hospital Association and Federation of American Hospitals, with the cooperation of such other groups as Blue Cross-Blue Shield and the Health Insurance Association of America.

Earle, a vice president of the American Hospital Association, is Executive Director of the steering committee of the three organizations.

Speaking on the same program, William M. Cohan, representative of the American Medical Association on the steering committee, declared that the cost containing campaign has been aimed substantially at the chiefs of medical staffs of each hospital in the nation. The head doctors have been asked to institute cost control measures in their hospitals.

"It is the doctors who order patients into hospitals, who prescribe treatment, who order surgery, who order X-rays and lab tests. And the doctors are already cooperating in the drive to hold down the escalation of costs by voluntary means," Cohan said.

Meanwhile, the U. S. Justice Department has refused to say whether it would contest on antitrust grounds the voluntary cost containment effort.

In a letter setting out the proposed program, the three groups had asked the Department's Antitrust Division to express its enforcement response to the program. In response, the Antitrust Division noted that such a program "would almost surely be considered an antitrust violation in many other industry contexts."

The federal communication did recognize that there might be significant differences between the hospital services industry and other industry. The communication did not prohibit nor discourage conduct of the VE programs, but merely said that no blanket statements about VE programs could be made by the Justice Department.

HEW Proposes Training Rules For Home Health Care

Rules for training home health care professionals or paraprofessionals have been proposed by the U. S. Department of Health, Education and Welfare.

Present or prospective employes of home health agencies certified by or applying for certification by the Social Security Administration would be eligible for training.

Funds will be awarded to public or non-profit private entities to plan training programs (including curricula which must be approved by the HEW Secretary prior to their use), recruit trainees and conduct the training programs. Procedures to be followed in applying for project grants are spelled out in the proposed regulations.

Preference will be given to applicants seeking grants for training programs in geographic areas with a population of at least one million persons or an entire state. Training personnel will be limited to home health aides in fiscal year 1978.

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Obituaries

RANDOLPH G. BROADDUS, M. D.

Dr. Randolph G. Broaddus, founder of Raleigh General Hospital in Beckley, died in a Chattanooga, Tennessee, hospital May 23. Doctor Broaddus was 81.

A graduate of the Medical College of Virginia and a native of Chance, Virginia, Doctor Broaddus moved to Beckley in 1928. He had practiced in Essex County, Virginia, and in Hinton.

He was a former Secretary of the Summers County Medical Society, and was President of the Raleigh County Medical Society in 1941. Doctor Broaddus was an honorary member of the West Virginia State Medical Association and the American Medical Association.

A former surgeon for the Chesapeake and Ohio Railway, Doctor Broaddus saw overseas service with the U. S. Army in World War I.

Survivors include two daughters, Mrs. Fern Cofer of Chattanooga and Mrs. Virginia Patel of Athens, Georgia; two sisters, Mrs. Fielding L. Dickinson of Loretto, Virginia, and Mrs. Martha B. Gresham, Richmond, Virginia; and a brother, Champ T. Broaddus, Tappahannock, Virginia.

* * *

ILONA P. SCOTT, M. D.

Dr. Ilona P. Scott, a radiologist with offices in Princeton and Beckley, died June 8 in Sidney Faber Medical Center in Boston. She was 59.

A native of Hungary, Doctor Scott received her medical degree from the University of Vienna in Austria and studied at Emory University in Atlanta, Georgia.

Doctor Scott was a member of the Greenbrier Valley Medical Society; the West Virginia State Medical Association and the American Medical Association; and was a Diplomate of the American College of Radiology.

She is survived by her husband, Elmore Allison Scott, a former vice-consul at the American Embassy in Vienna.

* * *

ROBERT R. STUART, SR., M. D.

Dr. Robert R. Stuart, Sr., who practiced medicine in Bluefield from 1927 until his retirement several years ago, died May 23 at his home. He was 87.

A pediatrician and a native of Tazewell, Virginia, Doctor Stuart was a graduate of the Medical College of Virginia. He was a former Secretary of the Mercer County Medical Society, and was an honorary member of the West Virginia State Medical Association and the American Medical Association.

Doctor Stuart entered medical practice in Pocahontas, Virginia, in 1914; and practiced in Gary, McDowell County, for 10 years.

Book Review

HANDBOOK OF OBSTETRICS & GYNECOLOGY, 6TH EDITION—Ralph C. Benson, M. D. Lange Medical Publications, Los Altos, California 94022. 722 Pages. 1977. Price $9.50.

Editor's Note: Below is another book review by Professor dr. Victoria Zinca of Bucharest, Romania. Doctor Zinca, Member of the International Academy of Cytology, requested her first book in September, 1977. She noted at the time medical books lost in the earthquake in Romania in March, 1977. Physicians who wish to help replace medical texts may send them to Doctor Zinca at this address: P. Box 637, P. Office L R-70100, Bucharest, Romania.

The *Handbook of Obstetrics & Gynecology, 6th Edition*, by Ralph C. Benson, M. D., is intended as a supplement to the primary book on obstetrics and gynecology. Certain aspects of obstetrics and gynecology have been condensed in the concise format, but clarity is maintained.

In this revision, more up-to-date information may be noted on the following subjects: sexually-transmitted diseases, the menopause, ultrasonography, amniocentesis, the determination of fetal maturity, hypertension and disorders of pregnancy, and hydatidiform mole and treatment of uterine bleeding.

Other new topics which have been added include the low-birth-weight neonate, amniotic fluid embolism, menstrual regulation, rape, premarital counseling, hysterectomy, colposcopy, neonatal surgical emergencies, and causes of asphyxia neonatorum.

The excellent, concise descriptions are chronologically presented, complemented by splendid illustrations which are simple and accurate and convey a definite idea.

The handbook should be of great value to medical students, nurse practitioners and midwives. For busy physicians, there is a convenient digest of data pertaining to the diagnosis and treatment of many obstetrical and gynecological disorders. The book is highly recommended.—Professor dr. Victoria Zinca, M.I.A.C.

REVIEW OF MEDICAL PHYSIOLOGY, 8TH EDITION—William F. Ganong, M. D. Lange Medical Publications, Los Altos, California 94022. 559 Pages. 1977. Price $12.50.

A very broad, in-depth and concise description of medical physiology is presented with relevance to clinical practice and problems.

Basic cellular physiology is well outlined early in this book. Ten chapters are devoted to the nervous system which neurologists, neurosurgeons, internists and other interested clinicians will find as a quick and easy, readable reference.

The section on endocrinology and metabolism outlines the detailed biochemical reactions and pathways in fat, protein and carbohydrate metabolism. The older Embden-Myerhof pathways and citric acid cycles are well outlined for reference. Newer concepts on intracellular cyclic AMP and cyclic GMP are presented. Cellular protein synthesis with respect to DNA and RNA is well diagramed and reviewed. The discussions of thyroid, pancreas and adrenal gland avoid being strictly clinical, but along with the basic molecular mechanisms present the very pertinent physiology. Calcium metabolism and bone physiology are presented briefly but adequately. The current physiology of the pituitary gland and gonads is well covered in concert with a great deal of clinical background.

The section on gastroenterology presents a fair amount of anatomy with its discussion. Bile salt metabolism, absorption and digestion are well detailed and offer considerable clarity. The so-called newer gut-hormones are included in the text.

Although the section on cardiology is factually accurate, those who wish to have a firm clinical foundation should refer to cardiology texts. Diagrams in the section on circulation appear to augment the script quite well.

Basic respiratory physiology including discussions pertinent to current pulmonary function testing is presented with appropriate consideration given to blood oxygen transport mechanisms. The formation and excretion of urine as well as the control of fluids and electrolytes are briefly, but adequately covered.

It appears that this paperback textbook has its most value as a reference to satisfy the gap for the practicing and academic physician with basic physiology. Numerous anatomical and physiological diagrams supplement the text and allow for quick and easy reading. The medical student in physiology will find this a concise but complete outline which needs supplementation by other manuals.—Alfred K. Pfister, M. D.

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Vol. 74, No. 9 September, 1978

Ectopic Pregnancy Following Tubal Sterilizations

T. A. ATHARI, M. D.
F. RAVANGARD, M. D.
Ohio Valley Medical Center, Wheeling, West Virginia; and Wheeling Division, West Virginia University Medical Center.

Ruptured ectopic pregnancy represents a major gynecologic emergency and presently accounts for six to seven per cent[6,7,9] of gynecologic deaths. Ectopic pregnancy, which occurs about once in every 100[1] gestations, is a relatively common human condition. It occurs only rarely in other species. A previous tubal ligation seems to be associated only with ectopic pregnancy in very few instances. With the rising incidence of tubal ligations, there may be expected to be a rising number of ectopic pregnancies associated with these procedures. There is a wide variation in the incidence of ectopic pregnancies and percentages of pregnancies associated with tubal sterilization ranging from 0 to 42.9 per cent.[8] It should be emphasized that a history of previous tubal ligation should not delay performance of the necessary diagnostic procedures to confirm the presence of ruptured ectopic pregnancy.

At the Ohio Valley Medical Center in Wheeling, West Virginia, a retrospective study was undertaken in which charts were reviewed for all patients with the surgical diagnosis of ectopic pregnancy and confirmed by pathology for the period from January 1, 1973, to December 30, 1976. A total of 34 cases of ectopic pregnancies was found, four of which were associated with previous tubal sterilizations (Table 1).

During this same period a total of 1,065 tubal sterilizations was performed. There were 859 cases done by laparoscopy and 206 cases performed as transabdominal or transvaginal. Four ectopic pregnancies with histories of previous sterilizations occurred during this same period. The women ranged in age from 28 to 37, and all were multiparous. The tubal sterilization surgery had been performed 9 to 40 months before the ectopic gestation. The most common presenting symptoms were lower abdominal pain and vaginal bleeding following a missed or scanty menstrual period. Two of the patients had a positive U.C.G. In all cases, the diagnosis was confirmed by histologic examinations. A summary of the cases is presented.

Case One

S. W., a 33-year-old, gravida 7, para 7, with one stillborn, had elective Pomeroy tubal ligation (verified pathologically) on April 26, 1971. She was admitted to the hospital on September 18, 1974, with left lower quadrant pain of four days' duration and vaginal bleeding for seven days. Her last normal period was July 28, 1974 (seven w.). Vital signs were normal. Pelvic exam revealed enlarged uterus with tenderness in the left adnexal region. Admission hemoglobin was 8.8, with a hematocrit of 27. U.C.G. for pregnancy on September 19, 1974, was positive. On laparotomy, left tube with ectopic pregnancy was ruptured; therefore, left salpingo-oophorectomy was performed. The patient's postoperative course was uneventful. Interval from tubal ligation to ectopic pregnancy was 40 months.

Case Two

B. B., a 28-year-old, gravida 3, para 3, had bilateral tubal ligation using Madlener-Pomeroy technique (verified pathologically) on June 29.

TABLE 1
Ectopic Pregnancy in OVMC
1973-1976

Total Number of Ectopic	*Ectopic Associated With Tubal Sterilization*	*Percentage*
34	4	11.7%

1972. She was admitted on February 14, 1974, with intermittent pain in the right lower quadrant of seven days' duration. Her last normal menstrual period had been January 27th and the amount of flow was less than normal. On pelvic examination the uterus was slightly enlarged and a five to six cm. mass was noted in the right adnexa. On laparotomy, the ampullary segment of the fallopian tube was ruptured. A right salpingo-oophorectomy was performed. Microscopic examination of the specimen confirmed the presence of chorionic villi. The patient's postoperative course was uneventful. Interval from tubal ligation to ectopic pregnancy was 19 months.

Case Three

M. M., a 37-year-old, gravida 6, para 3, abortus 3, had a vaginal tubal ligation as a classic Pomeroy technique on February 13, 1973 (verified pathologically). She was admitted on December 29, 1973, with lower abdominal pain. She had missed her last period. Vital signs were normal. On pelvic examination, an adnexal mass was palpable. Hemoglobin dropped from 11 gm. to 9.9 gm. in five hours. U.C.G. for pregnancy was positive. Culdocentesis produced dark nonclotting blood. On laparotomy, the distal segment of the left tube was ruptured and adherent to the left ovary. Bilateral salpingectomy was performed and microscopic examination confirmed the presence of trophoblastic tissue. The postoperative course was satisfactory and she was discharged on the fifth postoperative day. Interval from tubal ligation to ectopic pregnancy was nine months.

Case Four

B. B., a 32-year-old, gravida 3, para 3, had a laparoscopic sterilization on November 8, 1973. Her last period was approximately six weeks prior to admission. She was admitted on August 10, 1976, with lower left quadrant pain and a small amount of vaginal bleeding. Pelvic examination suggested a mass in the left adnexa. At the time of laparotomy, there was an obvious ectopic pregnancy of the left tube with bleeding from it. Left salpingo-oophorectomy was performed. On the second postoperative day the patient developed pulmonary infarction which was treated. She was discharged after 18 days in good condition. Interval from tubal ligation to ectopic pregnancy was 34 months.

A summary of the above four cases appears in Table 2.

Discussion

Abstinence and castration are the only two contraceptive methods which have perfect records of success. Of these two, only abstinence is 100 per cent safe: all others are associated with one or several potentially serious side effects. More and more adverse reactions are recognized as the number of users of each method increases and as the duration of their use is extended.

In our study, 11.7 per cent of ectopic pregnancies occurred after tubal sterilization. Harralson, Magell and Raddicks reviewed 96 patients with ruptured tubal pregnancies. Five had prior tubal ligations.[6] The incidence of patients with ruptured tubal pregnancies following tubal ligations was 5.2 per cent.[6] In Breen's study of 654 ectopics in 1969, only four had been preceded by tubal ligation (0.6 per cent).[9]

The incidence of ectopic pregnancy following laparoscopic sterilization is uncertain: it varies from 0 to 0.4 per cent by various authors.[7,15] In a total of 8,092 cases of laparoscopic sterilizations, the incidence of ectopic pregnancy was 0.07 per cent.[7] In our study of ectopic pregnancies following 859 laparoscopic sterilizations, the incidence was 0.11 per cent.

Since two of the patients in this series were ligated prior to the study period, the exact inci-

TABLE 2

Pertinent Data on Four Women with Ectopic Pregnancy Following Tubal Surgery

Name	*Age*	*Gravidity Parity Abortus*	*Type of Tubal Ligation*	*Interval Month*	*Special Findings*
S. W.	33	7:7	Pomeroy	40	Ruptured left tubal pregnancy
B. B.	28	3:3	Madlener Pomeroy	19	Ruptured right ampullary segment of tubal pregnancy
M. M.	37	6:3:3	Vaginal Pomeroy	9	Ruptured ectopic pregnancy in distal segment of left tube
B. B.	32	3:3	Laparoscopic	34	Ectopic pregnancy of left tube with bleeding

TABLE 3

Type of Procedure	*Number of Patients*	*Number of Ectopic Pregnancies*	*% Ectopic*
Laparoscopic	859	1	0.11
Transabdominal (Laparotomy)	645	3	0.46
Total	1,504	4	0.26

dence of ectopic pregnancy following tubal ligation by the Pomeroy or Madlener method had to be tabulated using the total number of ligations since 1971. Therefore, the incidence of ectopic pregnancy following Pomeroy or Madlener technique in our series was 0.46 per cent or approximately four times higher than with laparoscopic sterilization method (Table 3).

In the course of 4,200 laparoscopic sterilizations by Thompson and Wheeless, 21 surgical failures were noted with three ectopic pregnancies for an incidence of 18.7 per cent.[2]

Tatum and Schmidt reported ectopic pregnancies or percentage of pregnancies associated with different methods of tubal sterilizations as shown in Table 4.

The general accepted failure rate of Pomeroy tubal ligation is 0.25 to 2.0 per cent.[4,12] In the Prystowsky and Eastman study of 1,478 Pomeroy sterilizations, 10 pregnancies were observed and two were ectopic.[5] On 41 sterilizations using the Madlener procedure, there were three pregnancies of which one was ectopic.[5] From a practical viewpoint, perhaps the most important finding in this series of failures was the high incidence of tubal pregnancies.[5]

At the University of Louisville, of the 743 patients with salpingectomy sterilizations, 211 (28 per cent) had hysterosalpingographic follow-ups.[11] Four patients (1.9 per cent) showed fistula. The mechanism for fistula formation in Madlener or Pomeroy is likely to be sloughing of the tubal loop if the segment has not been excised or sloughing of the ends of the tube distal to the catgut ligature if the tubal segment has been excised.

Several studies of laparoscopic sterilizations have reported different uteroperitoneal fistula rates.[2,3,13,14,15] The studies have shown that if the fallopian tube is severed prior to adequate coagulation the chance of fistula is increased.[3,11] The damaged edge of the severed segments will slough, and raw ends of the tubes may recanalize. Ectopic pregnancy may then result by allowing sperm migration to the ampullary portion of the tube. The size of the zygote is more likely to prevent passage through the tubal constriction, increasing the chance of ectopic pregnancy.[8,10] Even if there is complete recanalization of the tube, the chance of ectopic pregnancy remains increased. Recoagulation of the fistula is not recommended as it will probably persist.[2,3,14,15] Laparotomy and religation of the tubes are recommended by some.

It should be pointed out that conception in the short-interval postlaparoscopy perhaps takes place prior to complete fibrosis in the lumen.[2]

Summary

This study reveals that approximately 12 per cent of ectopic pregnancies are associated with previous tubal sterilizations; therefore, the diagnosis of ectopic pregnancy should not be excluded because of a patient's past history of bilateral ligation or fulguration of tubes.

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TABLE 4

Route of Surgery	*No. of Women*	*No. of Pregnancies*	*No. of Ectopic Pregnancies*	*Ectopic % of Pregnancies*
Transabdominal	9,092	65	13	20
Transvaginal	8,190	35	1	2.9
Laparoscopic Tubal				
A. Coagulation & Transection	12,806	55	8	14.5
B. Coagulation Only	5,724	14	6	42.9

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Manuscript Information

Manuscripts to be presented for publication in *The West Virginia Medical Journal* should be typewritten, triple-spaced, on one side only of firm (no onion skin or flimsy), standard letter sized (8 1/2 by 11 in.) white paper. Wide margins (at least 1 1/4 in. on left) should be left free of typing. On the first or title page should be shown the title of the article, the name (or names) of the author, and his degrees. Pages should be numbered consecutively, the page number being shown in the right upper corner along with the surname of the author.

Where reference is made to generically-designated drugs, the first such reference must be followed by parentheses containing the most commonly known trade-name drug of that designation. In addition, a listing of all generic drugs mentioned in the article, with their trade-name equivalents, should appear at the end of the article.

A short abstract summarizing the manuscript should be included. This should be typed in double space on a separate page.

Authors are requested to submit a carbon copy with the original.

Illustrations should be numbered and their approximate locations shown in the text. Each should be identified by placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for reproduction should be done in black (India) ink on pure white. Photographs should be on glossy paper and minimum of about 5 by 7 in. in size. A legend should be provided for each illustration and, preferably, attached to it.

All scientific material appearing in *The Journal* is reviewed by the Editorial Board. Manuscripts should be mailed to The Editor, West Virginia Medical Journal, Box 1031, Charleston, W. Va. 25324.

Special Article

Continuing Medical Education In West Virginia

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Analysis of 703 questionnaires on continuing medical education (CME) completed by members of the West Virginia State Medical Association indicated great interest and concern of West Virginia physicians in CME and their individual CME needs. Over two thirds of the physicians responding to the questionnaire indicated that opportunity for obtaining Category 1 CME was available locally, and 72 per cent of these physicians had accumulated over 50 hours of Category 1 CME in the past year. Only 59 per cent of the physicians where local Category 1 CME was not available had accumulated like hours of Category 1 credit. The text includes discussion of barriers to obtaining creditable CME, mandatory requirements for CME, posture of specialty societies and boards regarding CME and recertification, and medical knowledge self-assessment programs. It is concluded that efforts in community hospital development of continuing medical education activities meeting criteria for Category 1 credit should be continued and accelerated.

WITH increased emphasis on continuing medical education (CME) throughout the country, West Virginia physicians especially concerned with the provision of continuing medical education opportunities felt the need to survey the physician's attitudes and feelings about his continuing medical education. If a requirement, should CME be a requirement for State Medical Association membership or re-registration of license? Is opportunity available for obtaining accredited CME at reasonable expense of time and money? How many hours of Category 1 CME credit were obtained in the last year? Where? And what are the practicing physicians' ideas on the direction of CME in West Virginia?

A survey questionnaire was sent to each member of the West Virginia State Medical Association and returned to the Office of Continuing Medical Education, West Virginia University School of Medicine, for analysis.

Replies were received from 732 physicians, a 38 per cent response. Twenty-nine questionnaires were not included in this analysis because of lack of information on the questionnaire, because the questionnaire was returned from outside the state, or because the questionnaire was received after March 1, 1978.

The 703 questionnaires were returned from 34 of the Health Services Access Areas (HSAA) described by Edward M. Bosanac in an earlier study of hospital patient flow patterns. Ten or more physicians in each of the following HSAAs responded to the questionnaire as follows:

#22	*Charleston HSAA	128
# 4	*Monongalia-Preston HSAA	88
#23	*Huntington HSAA	70
# 2	*Wheeling HSAA	61
#30	Bluefield-Princeton HSAA	55
#31	*Beckley HSAA	38
#15	*Parkersburg HSAA	35
#14	*Clarksburg HSAA	32
# 5	*Fairmont HSAA	21
#12	*Berkeley HSAA	17
# 1	Weirton HSAA	17
# 9	Elkins HSAA	17
# 3	Marshall HSAA	12
#35	Jefferson-Hampshire HSAA	11
#26	Montgomery HSAA	11
#33	Greenbrier-Monroe HSAA	10

Fewer than 10 physicians in each of the remaining 21 HSAAs responded to the questionnaire.

Each of the 37 HSAAs includes one or more hospitals. The largest of these catchment areas is the Charleston HSAA with a population of 307,000 (1977 projection), including the counties of Boone, Lincoln, Putnam, Braxton, Kanawha, and part of Clay County.

CME State Licensure Or Membership Requirement?

Arthur M. Osteen, Ph. D., in the October, 1977, issue of the American Medical Association's "Continuing Medical Education Newsletter," reported that there were 13 medical licens-

*HSAAs where there are institutions approved for awarding Category 1 credit for CME.

ing jurisdictions which were implementing continuing medical education requirements as follows:

Mandated by State Law:

California	New Mexico
Colorado	Ohio
Kansas	Rhode Island
Michigan	Wisconsin

State Medical Board empowered to require CME:

Maryland
Massachusetts (issued implementing regulations without special authorizing legislation)
Pennsylvania
Utah
Washington

In 11 other jurisdictions where CME is mandated by state legislation, or the Board of Medical Examiners is empowered to require CME, implementation had not yet occurred by October, 1977. These jurisdictions are Alaska, Arizona, Arkansas, Hawaii, Illinois, Iowa, Kentucky, Minnesota, Nebraska, New Hampshire and Puerto Rico.*

West Virginia is one of the 31 remaining states or territories that is without laws regarding continuing medical education.

As of December 26, 1977, 17 state medical societies had made policy decisions concerning CME for continued membership.[1] Such programs have usually started on voluntary bases, but by December, 1977, CME was mandatory for continued membership in 15 state medical societies.

The 15 medical societies implementing mandatory CME requirements are in the following states:

Arizona	New Jersey
District of Columbia	New York
Florida	North Carolina
Kansas	Oregon
Maine	Pennsylvania
Massachusetts	South Dakota
Minnesota	Vermont
Montana	

In summary, there are currently 25 states in which there is a mandatory requirement for continuing medical education in order to be licensed to practice medicine and/or to be a member of the state medical society.

*Note: A mid-1978 report by the American Medical Association's Department of Physician Credentials and Qualifications shows physicians in 35 states plus the District of Columbia must show evidence of CME activity to be eligible for relicensure and/or continuation of state medical society membership.

Because of developments in other states requiring CME to continue medical society membership and/or active practice, a survey question was formulated as follows:

> If there were a choice between either (a) Requirement of a specified number of hours of Continuing Medical Education for State Medical Society membership, or (b) Requirement of a specified number of hours of Continuing Medical Education for re-registration of license to practice, which would be your choice? _____(a) _____(b)

Eighty-two per cent of the physicians returning the questionnaire responded to this question. Of the 577 who responded, 307 chose (a), the medical society option; 223 chose (b), the license re-registration option; 29 indicated that they were opposed to both (a) and (b); 10 checked both (a) and (b), and eight were under the opinion that neither one would be satisfactory. Eighty-four more responses favored State Medical Association membership being tied to continuing medical education than CME requirements for re-registration of license. The choices between (a) and (b) followed no pattern of relationship to specialty or years of practice. Of the 29 responses that indicated the physicians were opposed to *both* choices, seven, or almost 25 per cent came from the HSAA with the largest respondent physician population of any HSAA in which there was no local Category 1 CME activity. Thirteen per cent of the physicians from this area, where 55 physicians responded to the questionnaire, were opposed to requiring CME for Association membership as well as being opposed to requiring CME for re-registration of license to practice medicine. Although the numbers are small, in comparison to the percentage of total responses that indicated opposition to both choices offered in the question (.03 per cent), it appears that philosophical opposition to mandatory CME was bolstered in the physicians in the area by unavailability of local opportunity to obtain Category 1 CME. Five of seven physicians in this area who indicated opposition to all mandatory CME indicated that the barrier to obtaining specified hours of Category 1 credit (another survey question) was indeed the unavailability of local opportunity and time away from practice (a problem enhanced by local unavailability).

As was anticipated, strong opposition to the subject of requiring CME was voiced in some of the comments, only a sample of which follows:

> I don't see why we have to make a choice of either of these alternatives (requiring

CME for Association membership or licensure re-registration). Required CME does not assure increased competence, nor does testing for re-licensure.

Don't believe in "forced," "governmental" intervention in medical affairs.

I do not agree with the concept of proof of CME nor with the requirements of CME for re-licensure, medical society memberships or re-certification.

I have sincere reservations about *mandatory* CME. An unmotivated person can attend a lot of meetings and get absolutely nothing constructive from them.

I do not feel you can legislate continuing medical education to force doctors to be better able to serve their patients.

Those who opposed CME as a requirement in any manner were in the minority, but extremely provocative in their comments. The majority apparently sense that CME is part of the way of life of medicine and that some evidence of participation is necessary, better controlled by the State Medical Association than by the state; but the majority that gave preference to the Association over the state was not overwhelming.

Medical Knowledge Self-Assessment

An increasingly popular avenue of acquiring CME is Medical Knowledge Self-Assessment. Medical Knowledge Self-Assessment approach to CME was first used by the American College of Physicians in 1968. Other specialty societies, associations, colleges and academies followed suit, and the current directory of such programs lists the following with the year the program was first offered.[2]

American College of Physicians	1968
American College of Radiology	1968
American Society of Anesthesiologists	1969
American Psychiatric Association	1969
American Academy of Ophthalmology and Otolaryngology	
Ophthalmology	1970
Otolaryngology	1971
American Society of Clinical Pathologists	1971
American Association of Neurological Surgeons	1971
American College of Surgeons	1971
American Neurological Association and the American Academy of Neurology	1972
American Society of Colon and Rectal Surgeons	1973
American Academy of Dermatologists	1973
American Academy of Orthopaedic Surgeons	1973
American College of Cardiology and the American Heart Association	1974
American College of Emergency Physicians and the Emergency Medicine Foundation	1974
American Academy of Physical Medicine and Rehabilitation	1974
American Society of Plastic and Reconstructive Surgeons	1974
American College of Chest Physicians	1975
American Academy of Pediatrics	1975
American Academy of Allergy and the American College of Allergists	1977
American Gastroenterological Association	1977
American Urological Association	1977

These voluntary assessment programs, usually designed to be taken optionally, closed or open-book, are available to association or academy members and non-members for a fee. They can be completed at home or office at the participant's convenience, are computer-scored, and vary in the credit hours applicable to the AMA's Physician's Recognition Award or other specialty society credits.

One question asked on the CME survey of West Virginia physicians was, "Have you ever participated in Medical Knowledge Self-Assessment Programs?" Specifically indicated as examples were the programs of the American College of Physicians, American College of Surgeons, American Academy of Pediatrics, and "others." No attempt was made to count how many respondents checked each individual program since the question was asked merely to assess the popularity of this type of continuing medical education program. A total of 687 physicians responded to the question—"yes" - 353, "no" - 334—indicating that this approach to CME has some popularity with West Virginia physicians.

In some specialties the Medical Knowledge Self-Assessment Programs have been, and others will be, designed to prepare physicians for board re-certification.

Specialty Society CME Requirements

The Journal of the American Medical Association (Vol. 238, No. 26, December 26, 1977) lists 12 medical specialty societies which have adopted formal CME certification programs as of August 1, 1977. Of these, seven require CME for membership. The following list indicates the

year the program was implemented (asterisk indicates CME is membership requirement).

1947 American Academy of Family Physicians*
1962 American Society of Abdominal Surgeons*
1973 American Academy of Emergency Physicians*
1974 American College of Obstetricians and Gynecologists
1974 American Society of Clinical Pathologists/College of American Pathologists
1975 American College of Radiology*
1976 American Academy of Dermatology
1976 American Association of Neurological Surgeons*
1976 American Psychiatric Association*
1976 American Society of Plastic and Reconstructive Surgeons*
1977 American Society of Colon and Rectal Surgeons
1977 American Urological Association

A survey question asked, "Are you a member of a medical specialty society which requires continuing medical education for membership?" Of the 678 physicians who responded, 280 indicated that the medical specialty society to which they belonged did require CME as a basis for continuing membership. There were 398 negative replies to the question.

Several respondents commented regarding the role of the specialty societies and boards in CME:

I feel the requirement for continuing education is in the province of the official specialty organization.—Orthopedist

Specialty re-certification requirements should be sufficient for re-registration of license to practice.—Plastic Surgeon

The thrust should be limited to specialty requirements. Having been a member of AAGP, now AAFP—the requirements were mandatory for membership. To require it at the state level for licensure is reversing the inputs since the applicants gain stature and ability when involved with their own field. —Obstetrician

I am already required by my specialty board to keep current in CME; therefore it doesn't matter what West Virginia does.—Family Practitioner

If specialty re-certification is available, this should be considered as prerequisite to re-registration of license to practice.—Plastic Surgeon

Satisfaction of specialty group or specialty re-certification should satisfy state society or licensing requirements.—Radiologist.

As a member of the American Board of Pediatrics and American Academy of Pediatrics, both of which require re-certification in Pediatrics in 1979, I strongly feel that this requirement is sufficient.—Pediatrician.

Opportunity For Category 1 CME in West Virginia

A review of the August 15, 1977, issue of JAMA reveals that West Virginia organizations planned to offer 4,124 hours of CME meeting criteria for Category 1 AMA credit in West Virginia in the 1977-78 academic year.

The following West Virginia institutions and organizations are accredited for sponsoring CME meeting Category 1 criteria:

Beckley Appalachian Regional Hospital

Veterans Administration Center—Martinsburg

West Virginia Academy of Ophthalmology and Otolaryngology

West Virginia Chapter of the American College of Surgeons

St. Mary's Hospital—Huntington

Charleston Area Medical Center

West Virginia Obstetrical and Gynecological Society

Broaddus Hospital—Myers Clinic

Ohio Valley Medical Center and Wheeling Hospital

Fairmont Clinic

Camden Clark Hospital—St. Joseph's Hospital—Parkersburg Academy—Parkersburg

West Virginia University School of Medicine; Charleston Division; Wheeling Division, and Affiliated VA Hospital—Clarksburg

Herbert J. Thomas Memorial Hospital—South Charleston

Weirton General Hospital (not accredited at time of this survey)

Jackson General Hospital—Ripley (not accredited at time of this survey)

The author is aware of CME activities sponsored by some of these organizations during 1977-78 which were not included in the AMA listing. The total hours available, therefore, is in excess of the 4,124 reported.

Local Availability Of Category 1 CME

A question asked on the survey was, "Does the hospital (one in which the physician is affiliated and/or nearest) offer Category 1 AMA continu-

ing medical education?" The question was asked to ascertain the percentage of respondents who are near or affiliated with a hospital that has been approved through the State Medical Association by the AMA or directly by the AMA (as is the West Virginia University School of Medicine) for sponsoring Category 1 CME.

Responding were 703: "yes"—171, "no"—171, "I don't know"—58. These responses indicate that for at least two thirds of the physicians Category 1 CME is potentially available locally.

Of the 703 questionnaires answered, 490 (70 per cent) were returned from nine large HSAAs in which there are approved sponsors of Category 1 CME programs. Where do the other 213 physicians who responded practice? More than 60 per cent (133) practice in the Bluefield-Princeton HSAA, the Elkins HSAA, the Marshall HSAA, the Jefferson-Hampshire HSAA, the Montgomery HSAA, the Greenbrier-Monroe HSAA, the Weirton HSAA, areas without Category 1-approved CME at the time of the survey, but probably with a physician population large enough to support an approved program. (Weirton General Hospital subsequently has been approved.)

The remaining 80 responses came from fewer than 10 physicians in each of 21 remaining HSAAs, with no responses coming from Tucker HSAA, Pocahontas HSAA, and McDowell HSAA.

These 21 HSAAs with fewer than 10 responses to the questionnaire are similar in that there is no local institution approved for Category 1 CME, with the exception of Barbour HSAA. Nine physicians in the Barbour HSAA responded to the questionnaire.

If one looks at the total number of physicians who practice in HSAAs where Category 1 CME opportunities are available, and who indicated the number of hours of Category 1 CME credit they had accumulated in the past year, and if one compares their experience with that of the physicians practicing where local Category 1 CME is available: there is a highly significant greater percentage ($P < .01$) of physicians in HSAAs with Category 1 opportunities who, in the past year, accumulated 50 or more hours of Category 1 CME credit (See Table). Eliminating Morgantown-Preston and Charleston HSAAs, areas with a great number of CME opportunities, does not alter the significance of the observation. Nor is this phenomenon directly related to a greater number of physicians in a community.

TABLE

Category 1 CME Credit Accumulated In The Past Year

Number of *hours*	Respondents from 10 HSAAs *with* local Category 1 CME *opportunities*	Respondents from 27 HSAAs *without* local Category 1 CME *opportunities*
Less than 50 hours	112	75
50 or more hours	283 (72%)	106 (59%)
Total of Physicians	395	181

It appears that the lack of local opportunities for Category 1 CME is a significant barrier for physicians in the 24 HSAAs from which there were responses. (Significant barriers are also assumed in Tucker, Pocahontas and McDowell HSAAs from which questionnaires were not returned.)

Of the 576 physicians who answered the question of the number of Category 1 credit hours accumulated in the past year, 32 answered "none," 155 reported one-49 hours, 268 reported 50-99 hours, 89 reported 100-149 hours, and 32 reported 150+ hours.

Two hundred forty-six physicians indicated that they had received the AMA Physician's Recognition Award at least once.

Barriers To Obtaining Category 1 CME

One survey question asked what barriers the respondent had to obtaining specified hours of Category 1 CME. The following barriers were suggested:

—Availability of accredited CME in my locality

—Time away from my practice

—Expense (other than loss of practice income)

—Other (specify)

The above barriers to obtaining specified Category 1 CME were checked 656 times. Many physicians checked more than one barrier, however, so the number of physicians with barriers was much lower than this figure (as one would anticipate since 216 questionnaires were returned from the Charleston and Morgantown areas where well over 3,000 hours of Category 1 CME were scheduled for the past year. There should be no barrier to most physicians in these areas — not even expense — since most of the hours are available without fee).

Cost. Although expense was listed as a barrier only 142 times, there were enough similar comments written in, i.e., "CME is a rip-off," to warrant some discussion. A review of past short courses for Category 1 CME credit in West Virginia shows the cost to physicians in fees to be

about $5 per credit hour when there was a fee. The CME offerings that "piggy-back" on undergraduate education in medical schools and on postgraduate education are usually without fees. In West Virginia this kind of CME offering makes up approximately 95 per cent of all the Category 1 CME scheduled.

In short courses designed specifically with the practicing physician in mind, fees must be charged to cover some of the cost of the courses. Voluntary health agencies and pharmaceutical companies often assist by paying honoraria and expenses for speakers from out of state. In general, in West Virginia, when fees are necessary, they are usually no more than $5 per credit hour for physicians and one half this amount for other practicing health professionals.

The "rip-off" comments from a number of respondents were apparently inspired by some of the national CME offerings, a plethora of which come across the practicing physician's desk almost daily. Some of these comments follow:

> Frankly, I see CME becoming a rip-off; i.e., the cost is rising and returns lessening.
>
> Many courses are so expensive anymore! $200 or $300 plus loss of time from practice.
>
> CME is getting to be a real RIP-OFF with tuition for some 5-day courses up in the hundreds of dollars.
>
> CME out-of-state has become too expensive, almost unrealistic—5 days of CME—$1000—incredible.

Availability. "Availability of accredited CME in my locality" was checked as a barrier to obtaining specified hours of Category 1 CME 193 times and, indeed, questionnaires were returned by 181 physicians from areas without local Category 1 CME. A few additional physicians in areas where CME is available locally, as well as where it is not, indicated that they had to go out of state to get CME pertinent to their specialty—radiology, allergy, thoracic surgery, ophthalmology, dermatology, otolaryngology, public health, for examples.

Some of the comments regarding availability of CME locally follow:

> No requirement should be made until each physician in the state can receive Category 1 credit in his (locality) town, office or home.
>
> Courses available in my specialty are out-of-state.—Ophthalmologist
>
> In my specialty of otolaryngology, it is necessary to travel to seminars elsewhere.
>
> The local physicians need to be more aware of the local possibilities for continuing medical education credit.
>
> Those physicians not fortunate enough to have Category 1 rounds, conferences, etc. in the primary hospitals must go to considerable expense and disruption of their practice to obtain "hours" which are frequently not of real benefit to medical knowledge relating to their specialty.
>
> Specialty CME non-existent in our area. —Orthopedist
>
> I would like to see a program instituted in which the physician does not have to leave his or her town in order to accumulate the necessary hours under CME.

Time Away From My Practice. The barrier most often checked (283 times) was "Time Away from my practice." Some physicians practicing by themselves in rural areas said there was no one to cover the medical needs of the community if he or she were gone. Even physicians practicing in areas with other physicians often felt that time away from practice was a barrier. Some felt that the times usually scheduled for CME activities were inconvenient for them. Some comments:

> I live about 30 miles and work 30 miles from Charleston. They have some good programs early morning, but it is almost impossible to attend these meetings. If some of the meetings were in evenings, [it] would be more convenient.
>
> WVU could offer more weekend programs for those finding it difficult to break away during the week.
>
> Time away from practice to get the required hours of credit is a problem. Need more CME programs on weekends.
>
> Practicing in rural area has several disadvantages, and one of them is continuing medical education. I should have self-assessment program to keep up to date or medical meetings should be scheduled in evening or Saturday afternoon or Sunday to make it possible for me to attend.
>
> As far as time, (CME) better on weekends (2-3 days).
>
> I am a solo practitioner and it is highly difficult to leave town for CME meetings.

Discussion

Physicians' Interest and CME Needs

The fact that 732 of the 1,950 physicians who were mailed the questionnaire took the time to respond is indicative that the subject of CME creates substantial interest. Over one third of the physicians who responded were interested enough to answer an open-ended question that asked for their comments and suggestions. On the basis of this response it seems incumbent on persons responsible for the development of CME in West Virginia to consider the needs and convenience of the practicing physician when developing programs.

Assessing the physician's needs for CME is paramount to successful CME. A physician's needs may be subjective and/or objective. As a professional whose training has been geared to lifelong learning, the physician usually is aware of deficiencies in cognitive medical knowledge which he desires to overcome through CME. Most frequently this is in the area of new development. The "What's New In . . . ." and "New Concepts In . . . ." type of CME courses are designed to bring knowledge of new developments to physicians.

Objectively, physicians' needs are identified through medical audit, PSRO, tissue committees, medical staff discussions, and discussion with patients. Those needs can be assessed only at the level of the physician's practice, and learning experiences based on these needs must be planned and conducted at the local level.

Courses developed on the basis of needs of the physicians attending the courses should have well-defined learning objectives so that the physicians know what to expect from the learning experience. In order to determine the effectiveness of the CME offering, there must be an evaluation of how well the learning objectives were attained.

Mandatory CME?

The choice expressed for requirement of specified hours of CME credit for state medical society membership over a similar requirement for re-registration of the medical license was not overwhelming. The question offered only these two choices as answers, and 125 physicians failed to make either choice. The question was on the back side of the questionnaire and may have been overlooked by some, but at least 29 physicians didn't make a choice because they were opposed to either answer as indicated by write-in opposition votes or their provocative comments. It is quite likely that some of the remaining non-responses of 96 physicians reflected their opposition to mandatory CME also.

The responses and non-responses to this question confirm the general opinion of CME authorities that mandatory CME is at the crossroads. The question was vigorously debated at a recent national conference of continuing medical educators, and there are "more negative than positives in today's mandatory CME structure."[3] The negative side of the debate expressed by Dr. Richard S. Wilbur succinctly summarized often-heard inconsistencies about CME:

> Unless there is an associated practice profile, we cannot be assured that the physician actually learned what he needed to know. There is no proof either that mandatory CME assures physician competence. Even if knowledge is gained, that alone does not assure that one can practice competently. Nor is mandatory CME a means of assuring adequate competence. Poor performance is more likely to be due to causes such as alcoholism, drug abuse, senility, laziness, or just plain overwork than to lack of competence. CME for these reasons, is almost irrelevant to any assurance of quality of care given to a patient. But CME has its values professionally, if done voluntarily.

Specialty Societies and CME

Medical Knowledge Self-Assessment Programs developed by the specialty societies appear popular with West Virginia physicians, with over 50 per cent of the total respondents having indicated participation in such programs. These programs are available from almost all the specialty societies, academies, or colleges and have considerable advantages for physicians who want to assess their specific competence or weakness in a specialty, as well as generally review specialty subjects on their own time at their convenience.

An increasing number of specialty societies are adopting CME certification programs for membership: a mandatory requirement in seven, voluntary in five others.

Closely related to specialty society CME certification programs is specialty board re-certification. All 22 medical specialty boards have policies advocating specialty re-certification. Fourteen of them have established dates when such programs will begin. Only four have at this time indicated such re-certification to be mandatory. Of these four, only the program of the American

Board of Family Practice is actually implemented. The other three mandatory programs and their implementation dates are:

The American Board of Surgery—1985

The American Board of Colon & Rectal Surgery—1985

The American Board of Thoracic Surgery—1985

The American Board of Internal Medicine has had a voluntary re-certification program since 1974 based on the American College of Physicians' Medical Knowledge Self-Assessment Program (MKSAP). Similar voluntary re-certification programs were scheduled for implementation by the American Boards of Allergy and Immunology, Obstetrics and Gynecology, Pediatrics, and Physical Medicine and Rehabilitation in 1977, and the American Boards of Otolaryngology and Radiology in 1978, American Boards of Plastic Surgery and Urology in 1980, and American Board of Anesthesiology in 1984.

The future may well see all the specialty boards responsible for certifying continued competence of specialists. Such developments would probably make the question of CME requirements for registration of license a non sequitur.

CME Availability in West Virginia

A considerable amount of Category 1 CME is available in West Virginia. As would be expected, however, it is heavily concentrated in the Morgantown and Charleston areas, and to a lesser extent in the Huntington and Wheeling areas.

Of the 37 Health Service Access Areas (HSAAs) in the state, 26 have no local sponsor of Category 1 CME. The largest number of respondents from any area without local Category 1 CME opportunities was from Bluefield-Princeton HSAA. Other areas with no local sponsor of Category 1 CME, and which have 20 or more permanently-licensed physicians (December, 1976, census) include Marshall HSAA, Elkins HSAA, Logan-Mingo HSAA, McDowell HSAA, Greenbrier-Monroe HSAA, and Jefferson-Hampshire HSAA. Consideration should be given to developing CME activities meeting Category 1 criteria in hospitals in these areas.

Areas which have 10 to 19 permanently-licensed physicians (1976 census) and no local Category 1 CME include the Petersburg HSAA, Tyler-Wetzel HSAA, Weston HSAA, Upshur HSAA, Jackson HSAA, Roane HSAA, Montgomery HSAA, Williamson HSAA, Hinton HSAA, Grant-Mineral HSAA, and Mason HSAA. As in Barbour HSAA, with similar physician population, resources may be available in some of these areas to sponsor local Category 1 CME.

The remaining eight HSAAs have licensed-physician population of fewer than 10 each.

Just because there is a local Category 1 CME sponsor in the area does not automatically imply that the CME needs of the physicians of the area are being met. As indicated earlier, many specialists' needs are not being met locally. Local scheduling may be inconvenient. The programs at the VA Hospital in Clarksburg conducted under sponsorship of the West Virginia University School of Medicine, and the VA Hospital in Martinsburg which is accredited for Category 1 CME are not well-attended by local physicians, suggesting that a physician is unlikely to avail himself of Category 1 CME opportunities on a routine basis unless such opportunities are staff activities in the hospital with which he is affiliated.

The survey points out the need for more hospitals to develop CME activities to the level that they can be approved for Category 1 credit.

The latest Hospital Accreditation Standards of the Joint Commission on Accreditation of Hospitals supports efforts for upgrading hospital staff education endeavors.

State's Hospital Libraries

These same JCAH standards contain Hospital Library criteria which are new and will serve to upgrade hospital libraries. A question on the survey questionnaire asked simply, "Is your hospital library of assistance to you in satisfying your medical information requirements?" There were 529 affirmative answers by physicians, 161 "no." Despite the rather positive feedback on this question, a recent survey of medical libraries revealed lack of professional guidance as flaws in the state's medical information network.

Under a contract with the United States Department of Health, Education and Welfare, West Virginia University is stimulating the development of a statewide biomedical information network, the nucleus of which will be the community hospital library.

The question of greater utilization of audio-visual materials, with some sort of periodic, routine distribution to community hospitals, especially those not large enough to sponsor Category 1 CME, should be explored by the medical school libraries and CME offices in the state.

Conclusions

Survey questionnaire responses from West Virginia physicians indicate a serious dedication to lifelong learning through CME. Thirty-five per cent of the state's physicians who responded to the questionnaire have received a Physician's Recognition Award from the AMA, compared with 19 per cent nationwide.

Efforts to develop local Category 1 CME sponsorship by community hospitals should continue and be strengthened. Course planners and those responsible for developing grand rounds and other hospital staff educational activities should give greater consideration to practicing physician convenience when scheduling. CME activities should be based on the needs of the physicians. The cost to participants of courses planned should be kept within reason.

Consideration should be given by the state's medical schools to developing Category 1 CME opportunities for physicians practicing in isolated areas, i.e., "circuit riding" CME programs, distribution of video tapes of grand rounds, and distribution of other audio-visual educational material.

Physicians should be kept informed of national developments in CME so that they are aware of developing pressures to attach more significance to the relationship between CME and quality of care than is warranted.

Acknowledgement

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There are books of which the backs and covers are by far the best parts.

CHARLES DICKENS

Medical Grand Rounds

From the West Virginia University Hospital

Edited By
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Sarcoidosis

Discussants:

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Intern in Medicine

THOMAS HODOUS, M. D.
Assistant Professor of Medicine

WILLIAM WELTON, M. D.
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Doctor Grigas:

Case Report

This was the first West Virginia University Hospital admission for this 52-year-old Caucasian female referred for the evaluation of sarcoidosis. The patient was in good health until August, 1977, when she noted a burning sensation in her eyes and intermittent visual blurring. In December, 1977, she noted the appearance of symmetric, painless, subcutaneous nodules on her forearms. In February, 1978, she developed a nonproductive cough and dryness of her eyes and mouth. In March, 1978, the still painless subcutaneous nodules began to involve her lower legs as well. She was seen by her referring physician who found hilar adenopathy on chest x-ray and performed a biopsy of a nodule which was reported to be consistent with sarcoidosis.

Physical examination revealed temperature 37°C, blood pressure 120/80, pulse 80, and respirations 18. Her lung, cardiac and abdominal exams were unremarkable. She had bilateral, rubbery cervical and axillary adenopathy. She had symmetric, raised, and nontender subcutaneous nodules on her forearms and pretibial areas.

Laboratory data: CBC, 6/60, urinalysis, serum protein, calcium, and LDH were normal. Alkaline phosphatase 160 and SGOT 66 were elevated. ESR was 52 mm/hr. Rheumatoid factor was negative. Arterial blood gases showed pH 7.5, pCO_2 32 mm Hg, and pO_2 67 mm Hg. Chest x-ray showed bilateral hilar adenopathy. ECG was normal. Spirometry and single breath diffusing capacity were normal.

Ophthalmology exam was remarkable only for a positive Schirmer test of 2 mm O.D. and 1 mm O.S. suggestive of keratoconjunctivitis sicca.

Review of the biopsy of the nodule showed noncaseating granulomata with frequently associated giant cells.

She was treated with artificial tears and will be followed carefully for other organ involvement.

Doctor Hodous:

Clinical Presentation

This interesting case illustrates one of the varied presentations of sarcoidosis, and one in which the course should be relatively benign although perhaps prolonged.

At the Seventh International Conference on Sarcoidosis, the disease was defined as "a multisystem granulomatous disorder of unknown etiology most commonly affecting young adults and presenting most frequently with bilateral hilar adenopathy, pulmonary infiltration, skin, or eye lesions."[1] The subject of two recent reviews,[2,3] sarcoidosis is a world-wide disease that is about as common as systemic lupus erythematosus, and affects women almost twice as often as men. In

the United States, blacks are affected approximately 10 times as often as whites, and the disease in blacks often runs a more aggressive course. It has been stated that sarcoidosis causes more disability in U. S. blacks than does tuberculosis.[4]

Sarcoidosis is notable for its diverse modes of presentation. At the time of diagnosis, the patient may be asymptomatic or acutely ill with marked constitutional symptoms. In one international study involving over 3,600 cases,[5] 40 per cent were detected by routine chest x-rays in presumedly asymptomatic people. Twenty-one per cent presented with respiratory symptoms (primarily nonproductive cough and dyspnea), 16 per cent with erythema nodosum, seven per cent with eye symptoms, and four per cent with skin lesions other than erythema nodosum. Approximately one quarter of patients will present with constitutional symptoms including fatigue, weight loss and malaise. Mayock reported fever in 17 per cent of his compiled population,[6] although others feel it is uncommon enough to warrant a careful search for another etiology.

Organ system involvement with sarcoidosis may be diverse. Ninety-five per cent of cases will have some intrathoracic disease, and these may be grouped by the x-ray pattern into stage 1 (hilar adenopathy), stage 2 (hilar adenopathy plus parenchymal disease), or stage 3 (parenchymal disease alone). The parenchymal pattern is quite variable and even nodular densities simulating metastatic carcinoma may be seen rarely. Although once thought to be rare, evidence of pleural involvement was found in 10 per cent of Wilen's recent series.[7] It is important to note that unilateral involvement in the thorax (either adenopathy or parenchymal disease) is distinctly uncommon and warrants a vigorous search for another etiology.

Peripheral lymphadenopathy may be found in over 20 per cent of cases, and may be generalized or localized to the cervical, axillary, or femoral regions. The nodes are usually symmetrical, firm, and nontender. Splenomegaly has been reported in over half of cases.

Most sources cite clinically apparent hepatic involvement in 20 per cent of cases, although liver biopsy has demonstrated noncaseating granulomata in 80 per cent. Here again, the variety of involvement is remarkable, and includes chronic active granulomatous hepatitis, postnecrotic cirrhosis, and an intrahepatic cholestasis that may mimic primary biliary cirrhosis.[8]

Acute ocular sarcoidosis may be the presenting feature and usually takes the form of anterior uveitis, often transient. More serious is the chronic disease which may involve any part of the eye. Keratoconjunctivitis sicca, found in our case, is not uncommon. When present, loss of vision is often due to secondary glaucoma. Slit lamp examination is indicated in all patients with sarcoidosis.

Other organ systems may show involvement in less than 10 per cent of cases; these include the heart, nervous system, joints and bones, muscles, and kidneys. For unknown reasons, significant cardiac sarcoidosis usually occurs in patients without other clinic evidence of disease, and not infrequently the diagnosis is made only at autopsy.[9,10] The clinical picture is one of serious arrhythmias in three-quarters of cases, and congestive heart failure in a quarter. While the cranial nerves may be involved early and transiently in the course of sarcoidosis, the central nervous system is not usually affected until later. Joint disease may be of two types: an acute immune complex mediated syndrome often associated with erythema nodosum that may mimic early rheumatoid arthritis, and a chronic granulomatous disease that rarely leads to joint destruction.

As in the case presented, the physical examination may lead quickly to the correct diagnosis in sarcoidosis, but in many cases it may be normal. Laboratory tests likewise are non-specific, and may be limited to an elevated erythrocyte sedimentation rate and serum globulin level, and occasional pancytopenia with eosinophilia. Hypercalcemia probably occurs in less than three per cent of cases;[11] is mediated by intestinal hypersensitivity to vitamin D, and occurs more often in patients with extensive disease.

The classic pulmonary function picture in sarcoidosis is one of restriction with decreased lung volumes, compliance, and diffusing capacity. Obstructive disease is rare in early uncomplicated disease but common in severe chronic disease with extensive fibrosis.

Clinical Course

It is generally felt that there is a progression of disease from stages I and II to stage III in sarcoidosis, although exceptions to this rule clearly exist. Approximately 65 per cent of cases presenting with stage I disease will eventually have resolution of radiologic findings.[5] Interestingly, this percentage is even higher if the patient also presents with erythema nodosum. For stages II and III resolution occurs in about 50 per cent and 20 per cent of cases, respectively,[5] implying that there is an increased degree

of irreversible hyaline fibrosis in later stages of the disease.

Overall, at least one third of patients coming to medical attention with sarcoidosis will have complete resolution of their disease. Another third will have mild residual symptoms, and 10-20 per cent will have severe impairment. In up to 10 per cent of cases, sarcoidosis will be the cause of death,[12] usually from progressive pulmonary impairment. It is important to emphasize the potential chronicity of sarcoidosis; patients may have active granulomata for decades.

Diagnosis

The noncaseating epithelioid granulomata seen in sarcoidosis are not pathognomonic, and the diagnosis must in large part be one of exclusion. The differential often includes tuberculosis, fungal disease, lymphoma, metastatic malignancy, and pneumoconiosis. How far to go and where to go to obtain tissue to confirm your clinical impression are both subjects of debate. This is particularly true in the case of a patient presenting with bilateral hilar adenopathy. Winterbauer, *et al*,[13] have suggested that such patients with no symptoms and negative physical exams, or with erythema nodosum or uveitis alone can be considered to have sarcoidosis without a tissue biopsy. The American College of Physicians, however, recommends tissue confirmation,[14] and suggests trans-bronchial biopsy (yield about 60 per cent), scalene node biopsy (yield about 80-90 per cent, even when not clinically palpable), or mediastinoscopy (yield almost 100 per cent). Becaues of limited availability and false positive tests with some batches, the Kveim test is not generally recommended.

Treatment

As in the case presented, many patients require no or only minimal therapy for their condition. Those with bilateral hilar adenopathy and erythema nodosum usually respond well to symptomatic treatment with non-steroidal anti-inflammatory drugs.

The generally accepted indications for using corticosteroids in treating sarcoidosis are persistent hypercalcemia or significant involvement of a major organ such as the lung, heart, eye, kidney, or central nervous system. Despite numerous studies, the long-term effect of steroids on pulmonary sarcoidosis is unclear, and the exact indications for treatment are debated. When used, however, most authorities agree that a minimum course of 6 to 12 months is required before trying to gradually taper the dose.

Anti-malarials have been successfully employed in the past for cutaneous disease, but because of their side effects are no longer commonly used. Anti-neoplastic drugs have been tried in some cases of severe, steroid-refractory sarcoidosis, but their use must be considered experimental.

Doctor Welton:

Skin Lesions in Sarcoidosis

This patient's presenting skin lesions were the more unusual asymptomatic subcutaneous nodules. These lesions are not to be confused with the more common erythema nodosum. Erythema nodosum is acute, red, hot, tender. It does not show the specific histologic findings of sarcoid.

Sarcoid frequently occurs in scars. This patient had some linear red papular lesions in small scars on her knees.

Other skin lesions seen in sarcoid are:

(a) Lupus pernio, a red purple plaque usually occurs over the nose.

(b) Red papules that occur more commonly about the nose and eyes.

(c) Flat-topped irregular papules that occur in various configurations, linear, annular.

(d) Diffuse infiltrative erythrodermic type.

Sarcoid may mimic many skin diseases and tumors. In a patient with systemic symptoms, it is worthwhile to search the skin carefully. Some insignificant lesion could give you a tissue diagnosis.

Histologically, sarcoid also resembles infections and foreign body granulomas. Special stains for acid fast, fungus and polarization for foreign body should be done. Some foreign bodies do not polarize such as Zirconium and Beryllium. Organisms are frequently not found in tuberculosis and leprosy that have reached this granulomatous stage. A blood test for syphilis is suggested.

Doctor Pearson:

Immunology of Sarcoidosis

There have been numerous theories regarding the aetiology of sarcoidosis. These have included suggestions that it is due to a form of atypical mycobacterial infection or is a reaction to environmental agents such as pine tree pollen. At the present time sarcoidosis remains a disease of unknown aetiology. However, since the beginning of the century, changes in immunological reactivity have been recognized as a feature of the condition. With the upsurge of interest in the immunology of disease over recent years, a

considerable amount of data has been collected regarding the changes found in sarcoidosis, much of it, whilst making the disease more interesting, makes it even more difficult to unravel.

Histopathology

The typical histological picture of sarcoidosis is of a noncaseating tuberculoid granuloma. The granuloma is formed by infiltrating lymphocytes and macrophages. Maturation of the latter results in the development of numerous epithelioid cells. Fusion of epithelioid cells with recently arrived macrophages results in the production of Langhans-type giant cells. It is important to recognize that this picture is in no way specific for sarcoidosis. Conditions with similar histology are legion. Giant cell granulomata can be seen in infections with viruses, fungi, protozoa, and metazoa as well as with spirochetes and mycobacteria. Reactions to beryllium and zirconium also typically produce lesions with histology similar to that seen in sarcoid. And giant cell granulomata are also a notable feature in allergic lung reactions of the extrinsic alveolitis groups (Farmers' Lung, etc.).

Giant cell granulomata may be produced by reactions to insoluble particulate material or by immune reactions. There is virtually no evidence to suggest that sarcoidosis is due to a foreign body type of reaction: insoluble particles cannot be detected in the granulomata by light or electron microscopy.

The immune reaction that is usually considered to produce granulomata is that of delayed hypersensitivity (cell mediated immunity). This is typified by the delayed reaction to tuberculoproteins. There is some evidence that deposition of antigen-antibody complexes formed at equivalence can also generate granulomata.[15] However, since such complexes also stimulate the induction of delayed type reactivity, it is uncertain whether granulomata can be produced by such complexes in the absence of cell mediated reactivity.

Antibodies and Immunoglobulins

Patients with sarcoidosis have no impairment of their ability to produce circulating antibodies to normally experienced antigens. Sarcoidosis patients produce similar levels of antibodies on immunization with pertussis and typhoid-paratyphoid as do normal controls.[16,17]

Hyperglobulinaenemia is a common finding and is usual in active and extensive sarcoidosis. Electrophoresis demonstrates that this is usually due to elevation of gamma-globulins although beta-globulin may be raised in patients with bilateral hilar lymphadenopathy and active disease.[18] Estimation of serum immunoglobulin levels show that the most frequent abnormality is an isolated increase of IgG, although the level of any or all classes may be elevated. IgM is most frequently found to be raised in acute forms of the disease with erythema nodosum.[19,20] These findings could be interpreted as being purely a non-specific phenomenon secondary to an active inflammatory process. However, I believe elevation of IgM early in the disease with later, predominant IgG elevation suggests an ongoing specific immune response to an antigen experienced for the first time at, or shortly before disease commencement.

Auto-Antibody Production

Auto-antibodies are a surprisingly frequent finding in patients with sarcoidosis. Rheumatoid factor (RF) has been found to have incidences, in different studies, of between 10 to 20 per cent.[20,21] There may be a weak association between rheumatoid factor titre and active lung involvement. Anti-nuclear antibodies may be found in up to 30 per cent of cases and organ specific antibodies such as anti-thyroid and anti-parietal cell antibodies have also been described as being of increased incidence in sarcoidosis.[20]

I think it is important that the presence of auto-antibodies not be taken to imply that they are necessarily of aetiological significance. Anti-nuclear antibodies and RF are found quite frequently in conditions other than lupus erythematosus and rheumatoid arthritis and are probably secondary to chronic inflammation. One can also suggest the possibility that auto-antibody production may reflect an inborn abnormality of immune regulation which would predispose to both auto-immunity and sarcoidosis.

Kveim Test

Since reliable Kveim-test suspension is not available locally, I shall only mention it briefly. Suffice it to say that when individual Kveim reagent batches have been adequately validated they produce positive reactions in at least 75 per cent of sarcoid patients and less than 2 to 3 per cent of positive reactions in patients with other conditions. Also, although the Kveim reaction is usually read at six weeks, biopsies performed soon after injection show a tissue infiltrate which would be compatible with a normal delayed-type response.

Cell-Mediated Anergy

A reduction in cell-mediated, delayed hypersensitivity skin tests is amongst the oldest recognized features of sarcoidosis. Previously tuber-

culin-positive patients are found to be tuberculin negative or to have reduced sensitivity after they develop sarcoidosis.[22] Reduced delayed sensitivity is also seen with other antigens such as those of mumps, pertussis and fungi.[16] However, this anergy is not total. Frequently, increased doses of test antigen will produce a positive response.[20] In addition, problems with the sort of infections which often cause the demise of patients with primary or secondary severe cell-mediated immune deficiency are not a notable feature of sarcoidosis.

The data regarding *in vitro* correlates of cell-mediated immunity (lymphocyte transformation, macrophage migration inhibition factor production, etc.) are conflicting. At least some of the differences between published series may be due to differences in technique. Many of those who claim to have demonstrated reduced lymphocyte responsiveness have incubated sarcoid cells in the patient's own serum, whereas normal lymphocyte responsiveness is usually seen when lymphocytes are incubated in normal human serum or fetal bovine serum. This suggests the presence of an inhibitory factor in the serum and indeed, reduced responsiveness of normal lymphocytes is seen when they are incubated in serum from sarcoidosis patients.[23,24]

The number of T lymphocytes in the blood as measured by the number of cells forming "rosettes" with sheep red blood cells, is often reduced in sarcoidosis. Again, this may be explained by the presence in the serum of a factor which inhibits this lymphocyte function. T-rosetting by normal lymphocytes is inhibited by sarcoid patients' serum.[25] Sarcoid sera contain a substance which binds loosely to lymphocytes. That this substance can be washed off easily suggests that it is probably not an anti-lymphocyte antibody. However, the inhibitory factor does appear to be of high molecular weight (> 100,000).

Immune Complexes

The recognition that erythema nodosum in other conditions such as tuberculosis is probably due to the formation of antigen-antibody "immune-complexes" led to a search for circulating immune complexes in sarcoidosis. Whilst there are a number of difficulties in the interpretation of tests for immune complexes, there are recent reports of identification of such complexes in the serum of some patients with sarcoidosis. Using the sensitive Raji cell assay one group found increased concentrations of immune complexes in one half of a group of 53 patients with pulmonary sarcoid.[26]

Discussion

Faced with a wealth of apparently unrelated data, one is forced at least to attempt to produce a scheme to fit it together. The explanation I put forward here is both personal and very hypothetical.

First, it seems highly probable that, at least in the earliest phase of the disease, there is a circulating antigen: viral, or possibly non-infectious, inhaled or ingested. Initiation of an immune response results in first IgM and then IgG production and formation of immune complexes of antigen and antibody. Current evidence suggests that the size of immune complexes and the class of their constituent immunoglobulins influences the type of disease produced, thus immune complex diseases can have differing clinical features. Immune complex formation may be responsible for at least some of the features of the acute phase of the disease and secondarily, deposition and localization of antigen in tissues. Antigenaemia may then cease. Tissue-localized antigen may proliferate locally, or by being resistant to degradation, remain at the site inducing granuloma formation by cell-mediated or insoluble-complex mechanisms.

Auto-antibody formation is most probably a secondary phenomenon, being due to alterations or release of cell antigens. Immune complexes themselves may induce anti-immunoglobulin (RF) production and these auto-antibodies may themselves influence the size and deposition of complexes.

Anergy is also probably a secondary phenomenon, and can be reproduced during severe inflammatory states in animals. The nature of the serum inhibitory factor is uncertain at present. One candidate is the immune complex itself, although data regarding changes in the levels of normal serum immuno-regulatory substances is not yet available.

Genetic factors are known to be of great importance in immune responses. It may be that the spectrum of immune response involved in sarcoidosis, or the inability to totally eliminate certain viruses is an inherent primary genetic disposing factor (we are presently involved in studying this possibility).

Acknowledgement

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To feel themselves in the presence of true greatness many men find it necessary only to be alone.

—Tom Masson

A message from . . .

The President

YOU'RE DOING A GOOD JOB!

YOU, the physicians of West Virginia, are to be congratulated on the improvement in medical care in our state over the past several years. Regardless of the criticism of doctors from the White House, HEW Secretary Joseph Califano and others, the profession can document clearly, here and elsewhere, significant gains for the general welfare of those we help and serve.

In West Virginia, our infant mortality rate has shown a heartening decline; access to medical care has improved; the quality of care provided in our more than 70 hospitals has risen; the number of those in our profession has increased; and the training of those new physicians who will be our successors and replacements has improved five-fold by realistic measurement over the past six years.

There is, of course, much more that must be accomplished. As your State Medical Association's new President, I pledge my best efforts to help you, working through and with your Association, to get the remaining job done.

Robert D. Hess MD.

ROBERT D. HESS, M. D., *President*

The West Virginia Medical Journal

Editorials

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author shall be held entirely responsible.

ADVOCACY

Mr. Carter has staked out claims for his acknowledgment as the advocate of the poor and the oppressed. That, as a matter of fact, just about covers the field these days—the oppressed being those weary workers taxed to the point of exhaustion to pay for those designated as poor. But physicians wonder who is to be the advocate of the *sick*.

Conflicting territorial claims have been filed for this rich lode of concerned voters by a variety of late-arriving claim jumpers. Their lineup is truly impressive including, as it does, ambitious and opportunistic politicians exemplified by Mr. Edward Kennedy; frightened incumbents exemplified by Mr. Carter; bureaucratic personnel with an eye to expanding their favorite job market; health insurance companies and employer groups with the undeniably praiseworthy notion that a penny saved is a penny earned.

Prior claims, however, along with clear deed and title to this turf belong to the medical profession. Historically, there had been no other claimant until the opportunity for political harvest became apparent to political demagogues.

And what strange and tainted claims for title of advocate of the sick are now being made by these interlopers. In support of these late claims, initial charges of poor stewardship of medicine's advocate role failed to stand up under the evidential weight of worldwide recognition that medical care in the United States is, indeed, the best available on this planet.

Next, allegations were made that the care did not extend to all citizens. This has not been borne out by actuarial studies which now are hard pressed to find any significant numbers not covered by some form of health care insurance.

Charges that insufficient numbers of physicians could be made available to provide care adequately for all have been refuted by evidence that physician population in the past 20 years has increased at three times the rate of total population increase. Indeed, this charge has turned 180 degrees and has now become a claim that the medical profession has over-populated itself.

The remaining allegation is most difficult to refute. It cites high medical care costs as evidence that medicine's advocacy of the sick has been too good and too successful. Via a strange process of logic, a conclusion is reached that in the interest of everyone a new, less militant, less determined and less successful advocate of the sick is thus needed. Somehow we find it difficult to picture the general public accepting the proposition that less is better when it comes to medical care.

Medical care costs can be cut in one of two ways: cut services, or cut quality. We, frankly, think very little of either alternative. In either case, what we are talking about is the rationing of medical care.

It is the proper function of an advocate to insist on the best for his cause or his client. If we, the medical profession, are to make cost our primary concern and join in with the bandwagon blare for rationing medical care, who will be left to speak for the sick?

Quality must continue to be our primary medical concern. That has been our traditional concern. We have done well at it. We should be proud rather than apologetic for our quality accomplishments.

As members of the general public, physicians can be concerned about high medical care costs, just as we are concerned about high taxes, high governmental costs, high food and housing costs and high employment costs. As physicians caring for the sick, any concern about cost must be a distant second at best.

In any other arrangement of priorities, the sick patient is the loser. Concern over the in-

tegrity of a fund cannot take precedence over concern for the welfare of a patient.

If *we* put dollar sign first and patient second, no one else will care. No one else really gives a damn about the sick.

PROPOSITION-13 ENLIGHTENMENT

Perhaps it is the most important political phenomenon of the past quarter century. The Proposition-13 vote has been examined, analyzed and speculated upon to an unprecedented extent. Yet its connotations continue to be endlessly fascinating.

Were politicians really shocked at the results? A highly unlikely possibility. One loses dog catcher elections missing the leanings of the electorate that badly. Why then, recognizing the feelings and intentions of the voters, did they not hasten to pass legislation mitigating tax inequities addressed in Proposition-13?

The answer, of course, lies in the secondary effects of the passage of Proposition-13 which we are now witnessing. It means that certain people in government must, of necessity, be fired. Now, to a politician, this is serious, for besides certain feelings of kinship for these newly unemployed derived from feeding at the same trough, other feelings of regret, loss and anxiety are stirred because each lost job represents a certain lost vote. Votes are, after all, the beginning and the end of any political endeavor.

A politician will take his chances with the unknown or uncommitted voter and go with the sure vote every time. This is one reason politicians do not like sunset laws which might decimate the bureaucracy. This is why government commissions, committees, bureaus, programs and departments live superannuated lives far beyond whatever utility they may have once had. There is a built-in reluctance to vote anyone out of work.

Another thing that worries the politician is the state of mind of those bureaucratic ex-colleagues of the newly unemployed. How anxious have they been made by this threat or that near miss? Are they fearing who might be next? Are they anxious enough or loyal enough to their former companions to throw sand in the machinery of government just when the situation calls for purring governmental sounds? Or, God forbid, might they vote against that politician partially responsible for making them thus anxious?

Government employees are a large and growing group. Many of the lowly and unknown have powers to delay, inhibit or somehow foul up pet projects or services from which politicians love to gain advantage with their constituents. These lowly ones are able to extract a penalty from those in the lists failing to note their needs.

The whole Proposition-13 issue suggests that politicians are inherently incapable of voting against such a potent group as the government bureaucracy or any part of it. It suggests that in order to relieve themselves of the yoke of many burdensome, costly, inefficient and ineffective government programs, the voters of this country are forced to rely on the referendum route to further limit the profligacy of government spenders.

It might be just too much to expect that our elected officials will ever be able to change their habits. If all of this is indeed the case, what a valuable lesson to learn! Bring on those petitions! Show me where to sign!

Our Readers Speak

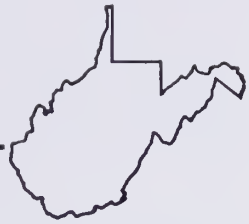
In preparation for a September meeting of the National Institute of Allergy and Infectious Diseases to consider the feasibility and advisability of making the insect sting kit available to certain trained categories of medical and lay persons, without a specific prescription by a physician, I would be interested in receiving information and comments by the readers of this Journal on the following questions:

1. Have you any knowledge of a fatal reaction to an insect sting or drug or food? If so, I would appreciate as much detail as possible, including information concerning the time interval between contact with the offending agent and death.
2. If you know of such a fatality or fatalities, in your estimation, would an immediate subcutaneous injection on the scene of a premeasured dose of epinephrine 1:1000 (0.3cc to 1.5 for adult 0.2 to 0.3cc for children) have afforded a different outcome?
3. Have you any knowledge of adverse effects of subcutaneous injections of epinephrine 1:1000 in the above dosages? If so, again I would appreciate as much detail as possible.

We would certainly appreciate any information you can supply.

Claude A. Frazier, M. D.
Doctors Park, Building 4
Asheville, North Carolina 28801

GENERAL NEWS



Fitness, Obesity, Diet Therapy To Be Conference Subjects

A session on physical fitness, obesity and diet therapy will be among the highlights of the 12th Mid-Winter Clinical Conference to be held in Charleston next January 26-28 at the Holiday Inn Charleston House.

The Co-Chairmen of the Program Committee, Drs. Ralph H. Nestmann and Joseph T. Skaggs, both of Charleston, announced that the session will be held on Friday afternoon (January 26) for physicians and developed as a public program Friday evening.

Fred L. Allman, Jr., M. D.

The annual continuing education event is sponsored by the State Medical Association and the West Virginia and Marshall University Schools of Medicine.

The co-chairmen also announced that other general subject areas for the conference will include "Current Practices in Immunization," "Coronary Artery Disease" and "Current Concepts in Hematology."

The conference schedule also will include a Friday evening physicians' session, held concurrently with the public session, and a dinner program Saturday evening.

The Friday evening physicians' session will consist of a presentation on physicians' Individual Practice Associations (IPAs).

Three physicians—from Atlanta, Boston, and the Marshall University School of Medicine in Huntington—will be the speakers for the two Friday sessions on physical fitness, obesity and diet therapy. They are: Drs. Fred L. Allman, Jr., founder (in 1969) of The Sports Medicine Clinic, a private clinic, in Atlanta; Ruth C. Harris, Professor and Chairman of Pediatrics at Marshall, and Frederick J. Stare, Professor of Nutrition, Department of Nutrition, Harvard University School of Public Health, in Boston.

"Overuse Syndromes in the Recreational Athlete" will be Doctor Allman's topic, while Doctor Harris will discuss "Our Overgrown Children." Doctor Stare will speak on "Management of Cholesterol and Triglycerides."

Football Player

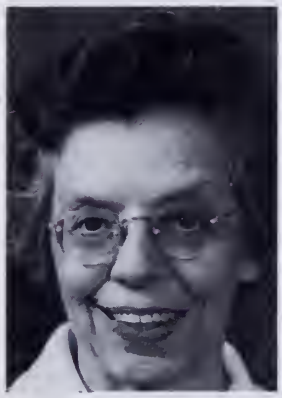
Doctor Allman, an orthopedic surgeon, was a football player in high school and college. The clinic he established probably was the first such private clinic in the United States to be devoted exclusively to the prevention, diagnosis, treatment and rehabilitation of athletic injuries.

He played football at the U. S. Merchant Marine Academy in New York in 1945-46 and at the University of Georgia (as guard) from 1947-51.

Doctor Allman is the author of more than four dozen publications in the field of sports medicine and physical fitness, including, "The Executive Fitness Desk Diary," a 182-page book devoted exclusively to executive health. He has lectured and presented workshops in 35 states and four foreign countries on subjects concerning athletic injury-prevention, treatment and rehabilitation.

Chairs AMA Committee

Doctor Allman has produced three sound movies on knee injuries in athletes and two sound movies on prevention of athletic injuries.



Ruth C. Harris, M. D.

Frederick J. Stare, M. D.

He currently is orthopedic consultant for the Georgia Tech and Atlanta public schools athletic teams, and was Chairman of the American Medical Association's Committee on Exercise and Physical Fitness in 1973-74. In 1971, he was appointed to the National Football League (NFL) Player Relations Association to serve on a panel of orthopedic surgeons to examine professional football players who have initiated injury grievance claims. Among numerous other sports-related appointments, he was Chairman of the Board of Trustees of The Sports Medicine Foundation of America, Inc., from 1972 to 1977.

Doctor Allman also is the recipient of a number of awards, including the American Alliance for Health, Physical Education and Recreation William G. Anderson Award in recognition of meritorious service to the profession of health, physical education and recreation, in 1976 and, in 1973, an Honorary Lifetime Membership in the National Athletic Trainers Association and the Georgia Athletic Coaches Association. He also was the recipient of the Contribution to Amateur Football Award, National Football Foundation and Hall of Fame, in 1972.

Doctor Allman was graduated from the Medical College of Georgia in 1955. He interned at Charity Hospital in New Orleans, and completed graduate work in orthopedics at Tulane University Medical School from 1956 to 1960. His memberships include those in the American College of Sports Medicine, the American Board of Orthopaedic Surgeons, the American Academy of Orthopaedic Surgeons, and the American Orthopaedic Society for Sports Medicine.

Comes From Columbia University

Doctor Harris came to Marshall in 1976 from New York City, where she had served in a variety of teaching posts in pediatrics at Columbia University since 1947.

A native of Mount Vernon, New York, Doctor Harris was head of the Chemistry Laboratory at Babies Hospital in New York City from 1959 to 1965. She was Visiting Professor, Department of Pediatrics, Severance Hospital and Yonsei University, Seoul, South Korea, from 1968 to 1970.

Currently, she is Medical Consultant for the Holt Adoption Program, Inc., in Eugene, Oregon, and Technical Director, The Children's Liver Foundation, Inc.

Doctor Harris was graduated from Barnard College and received her M. D. degree in 1943 from the Columbia University College of Physicians and Surgeons.

She interned at Philadelphia General and completed residencies and additional training at Willard Parker Hospital in New York City, Children's Hospital, Cincinnati; Babies Hospital, New York City, and Charity Hospital, New Orleans.

Currently, Doctor Harris holds Associate Staff appointments in Pediatrics at Cabell-Huntington Hospital and St. Mary's Hospital in Huntington.

She is the author or co-author of some 54 scientific articles and abstracts, the author of eight letters to the editor, and the author of, or a contributor to, eight books. She was the author of the Chapter on "Liver Disease Neonatology" appearing in the book, *Diseases of the Fetus and Infant*, published in 1973. Her letters to the editor have appeared in The Journal of Pediatrics, Pediatrics, American Journal of Diseases of Children, Nutrition Reviews, The New England Journal of Medicine, and Pediatric News.

Headed Nutrition Department

Doctor Stare was Chairman of Harvard's Department of Nutrition from 1942 through 1976.

He is the author of the nationally-syndicated newspaper column, "Food and Your Health," some 350 technical research and review publications, and numerous lay articles. He is a co-author of the books, *Eating for Good Health*, *Scope Manual on Nutrition*, *Living Nutrition*, *Nutrition for Good Health*, *Panic in the Pantry*, and *Eat OK—Feel OK*.

Doctor Stare is a consultant to numerous voluntary and governmental agencies and to a number of food companies and trade associations. He is Director of the Center for Nutrition Education and American Council on Science and Health.

A native of Columbus, Wisconsin, Doctor Stare holds B. S., M. S., and Ph. D. degrees from the University of Wisconsin. He received his M. D. degree in 1941 from the University of Chicago.

Doctor Stare went to Harvard in 1942 after interning in medicine at Barnes Hospital in St. Louis, Missouri.

He holds honorary degrees from Suffolk University (1963), the University of Dublin, in Ireland (1964), and Muskingum College (1977).

Doctor Stare is the recipient of a number of awards, including the Goldberger Award of the American Medical Association (1962), the Conrad A. Elvehjem Award of the American Insti-

tute of Nutrition (1969), and the Henderson Award of the American Geriatric Society (1977). In addition, he is an Honrary Member of the American Dietetic Association and an Honorary Fellow of the Royal Irish College of Physicians.

Program Committee

The conference will begin Friday afternoon and conclude at noon on Sunday.

Serving on the Program Committee with Doctors Nestmann and Skaggs are Drs. William O. McMillan, Jr., of Charleston; C. Carl Tully, South Charleston; Robert L. Smith, Morgantown, and Maurice A. Mufson, Huntington.

Additional details, including other conference speakers, will be provided in later issues of *The Journal* as the program is completed.

Marshall Completes Selection Of Department Chairmen

The last two departmental chairman vacancies in Marshall University's School of Medicine have been filled, Dr. Robert W. Coon, MU Medical School Vice President/Dean, has announced.

Leonard B. Victor, M. D., of the University of Tennessee College of Medicine, Memphis, and Albert G. Moat, Ph. D., of Philadelphia's Hahnemann Medical College have accepted appointments as the respective heads of Marshall's Pathology and Microbiology Departments. Both assumed their new duties in August.

At Tennessee, Doctor Victor was Professor of Pathology, Chief of Clinical Pathology, Chairman of the Laboratory Solving Module, Professor of Nuclear Medicine and Professor of Clinical Laboratory Science.

The Schenectady, New York, native joined the UT faculty in 1972, having previously taught at Vanderbilt University, Meharry Medical College and the University of Rochester.

Earning his B.A. degree from New York University, Doctor Victor received his M.D. degree from Brussels University and the T.M.D. from the Royal College of Tropical Medicine. After a rotating internship at several Buffalo, New York, hospitals, he took his pathology internship and residency at the University of Rochester and Strong Memorial Hospital.

In the summer of 1974, Doctor Victor participated in an advanced management program in health systems management at the Harvard University Graduate School of Business.

Active in various professional organizations, he is President of the Tennessee Society of Pathologists. He is the author of several scientific articles and in 1975-77 served as co-director of a cancer design project at the University of Tennessee under a National Cancer Institute contract.

Doctor Moat, who joined Hahnemann's faculty in 1952, has been Professor of Microbiology and Director of the Graduate Program in Microbiology.

A former research fellow at Cornell University, Doctor Moat has been a visiting professor in Cornell's Development and Physiology Section of Genetics.

The New York State native earned his B.S. and M.S. degrees from Cornell University. Doctor Moat's Ph.D. degree is from the University of Minnesota.

He has received several awards and honors including a Lalor Foundation Research Fellowship and a United States Public Health Service (USPHS) Special Research Fellowship.

The author of more than 40 scientific papers and reviews, Doctor Moat has completed the manuscript for a textbook on microbial physiology. He has received research support from the American Cancer Society, Pender Fund for Cancer Research, Squibb Institute for Medical Research, the USPHS National Institutes of Allergy and Infectious Diseases, and six successive grants from the National Science Foundation.

Doctor Moat is a member of several professional societies, including the Society of Sigma Xi, American Academy of Microbiology, American Chemical Society and the American Association for the Advancement of Science.

The Medical Association's Headquarters Office recently had an unusual "visitor" — almost. In Charleston for a few days was the Goodyear blimp "Mayflower." We don't know that this photo has any medical or other scientific significance—but the blimp was a pretty addition to the downtown sky on a nice summer afternoon.

Continuing Education Activities

Here are the continuing medical education activities listed primarily by the West Virginia University School of Medicine for part of 1978, as compiled by Dr. Robert L. Smith, Assistant Dean for Continuing Education. The schedule is presented as a convenience for physicians in planning their continuing education program. (Other national, state and district medical meetings are listed in the *Medical Meetings* Department of *The Journal.*)

The program is tentative and subject to change. It should be noted that weekly conferences also are held on the Charleston and Wheeling campuses as well as in Morgantown. Further information about these may be obtained from: Division of Continuing Education, WVU Medical Center, 3110 MacCorkle Avenue, S.E., Charleston 25304; Office of Continuing Medical Education, WVU Medical Center, Morgantown 26506; or, Office of Continuing Medical Education, Wheeling Division, WVU School of Medicine, Ohio Valley Medical Center, 2000 Eoff Street, Wheeling 26003.

Sept. 7, 8	Morgantown	Hal Wanger Family Practice Conference
Sept. 15	Morgantown	Cleft Palate Teaching Day
Sept. 22, 23	Wheeling	Seminar on Obstetrics and Gynecology
Oct. 5	Morgantown	Annual Pediatric Day
Oct. 6, 7	Morgantown	Critical Care Symposium
Oct. 14	Wheeling	Medicine Day Seminar
Oct. 20, 21	Charleston	Medical and Social Problems of the Elderly
Oct. 27, 28	Morgantown	American College of Surgeons

Flood Family Establishes College Scholarship

Establishment of a scholarship at West Virginia Northern Community College in Weirton by the family and friends of Dr. Richard E. Flood, Miss Estelle Flood and the late Mrs. William Fahey (formerly Mildred Flood), all of Weirton, recently was announced.

The scholarship is earmarked for tuition assistance to area students who seek careers at Northern in health-related professions. It has been established on an income-producing basis to provide scholarship funds in perpetuity.

Honorees are the late Mrs. Fahey, a bookkeeper for many years in the medical office of her brother, Doctor Flood; her sister, Miss Estelle Flood, who has worked for many years in the Flood office, and Doctor Flood, a leader in local, state and national medical affairs, and a Past President of the State Medical Association.

Mrs. Fahey, widow of the late William Fahey, died April 26, 1978.

Dr. Daniel B. Crowder, President of the College, commented. "We at Northern hold the friendship and support of the Flood family in high esteem. It is an honor to share with them this opportunity to provide eduation assistance for deserving students."

The family and friends of the Floods were invited to participate in the tribute by making donations to the West Virginia Northern Community College Foundation.

Dr. Seigle W. Parks of Charleston, the State Medical Association's President in 1965-66, proudly displays the third-place ribbon he won in watercolor competition held as a part of the American Physicians Art Association judging during the American Medical Association Annual Meeting in June. Doctor Parks has been active in the group only three years, and the ribbon won in St. Louis was his fourth in that short period. His seascape of a Monterey Peninsula area in California also is shown in the photograph above taken by the AMA's Joe Fletcher.

Review A Book

The following books have been received by the Headquarters Office of the State Medical Association. Medical readers interested in reviewing any of these volumes should address their requests to Editor, *The West Virginia Medical Journal*, Post Office Box 1031, Charleston 25324. We shall be happy to send the books to you, and you may keep them for your personal libraries after submitting to *The Journal* a review for publication.

Genetic Screening: Programs, Principles, and Research, by the National Academy of Sciences (Committee for the Study of Inborn Errors of Metabolism, Division of Medical Sciences, Assembly of Life Sciences, National Research Council). 388 pages. 2101 Constitution Avenue, N.W., Washington, D. C. 20418. 1975.

Review of Medical Microbiology, 13 Edition, by Ernest Jawetz, Ph. D., M. D.; Joseph L. Melnick, Ph. D.; and Edward A. Adelberg, Ph. D. 550 pages. Price $12. Lange Medical Publications, Los Altos, California 94022. 1978.

Current Obstetric & Gynecologic Diagnosis and Treatment, 2nd Edition, by Ralph C. Benson, M.D. 976 pages. Price $18. Lange Medical Publications, Los Altos, California 94022. 1978.

CME Program of Ripley Hospital Accredited By Association

The continuing medical education program of Jackson General Hospital in Ripley has been accredited by the State Medical Association through its Committee on Medical Education and Hospitals.

The hospital was granted a one-year provisional accreditation for a newly-developing program, effective June 29, 1978. Credit for Category 1 of the Physician's Recognition Award of the American Medical Association is effective retroactively to the date of the site survey, May 26, 1978.

Serving on the survey team were Dr. Dennis S. O'Connor of Huntington, Chairman, and Robert D. Whitler, Director of Consumer and Continuing Education, Charleston Division, West Virginia University Medical Center.

Including Jackson General, the CME programs of 14 state hospitals and four medical organizations have been accredited by the State Medical Association.

Record Number Of Women In New WVU Medical School Class

Women compose nearly one fourth of the new class which entered the West Virginia University School of Medicine in late August.

The 21 women admitted this year exceed by one the record set last year for female students in an entering class. All of the women are residents of West Virginia as are 66 of their 67 male classmates.

The 87 West Virginians come from 28 counties. Kanawha County is home for the largest number—19. Monongalia County has 12 and Ohio County has 10.

Those admitted completed their undergraduate education at 30 different institutions—49 were students at WVU, 14 attended Marshall University or West Virginia colleges, and 25 attended 20 different out-of-state colleges or universities.

Despite a decrease in the number of inquiries received—down to 1,070 from the more than 1,200 received in 1977—selection of the new class was again a difficult task for the 12-member Committee on Admissions.

Of the 336 applications sent to West Virginians, 213 were returned as were 127 of the 201 sent to out-of-state residents. Interviews were granted to 201 West Virginians and to 57 non-residents.

The overall grade point average for the accepted candidates this year was 3.57, and the science average was 3.55 (4.0 is perfect—all A's).

Members of the class include:

BARBOUR COUNTY: Philippi—David M. Cheney.

BROOKE COUNTY: Follansbee—Marguerite Bonaventura; Weirton—Burt Fazi; Wellsburg—Mark W. Minor.

CABELL COUNTY: Huntington—Ronald L. Gross, Regis W. Haid, Barbara A. McQuinn, Rachel C. Owens and Christine H. Wolf.

CALHOUN COUNTY: Grantsville—Cathy S. Jones.

CLAY COUNTY: Ivydale—Kimberly A. Boggs.

FAYETTE COUNTY: Montgomery—Victor C. Lee.

GILMER COUNTY: Glenville—Henry D. Windler.

GRANT COUNTY: Maysville—Carl E. Weimer; Petersburg—William R. Hutson.

GREENBRIER COUNTY: Lewisburg—James P. DeHaven.

HANCOCK COUNTY: Weirton—Barbara A. Clark, Norman D. Ferrari and Rosanna D. Sikora.

HARRISON COUNTY: Clarksburg—William D. Smith.

JACKSON COUNTY: Ravenswood—Stephen H. Bush.

KANAWHA COUNTY: Belle — James D. Clay and Timothy L. Mullins; Charleston—Anthony L. Burke, Glenn R. Goldfarb, Theodore A. Jackson, Katherine A. Jacobs, William A. Morton, John G. Nicholas, Joseph M. Petersen, Terry L. Schwartz, Kimberly L. Skaff and James M. Waldeck; East Bank—Harry R. Reynolds; Pratt—David L. Soulsby; St. Albans—Jill D. Bross, John E. Dennie and Joe J. White; South Charleston — Brian D. Brattlof and John T. O'Donnell.

LOGAN COUNTY: Logan—Mark D. White.

MARION COUNTY: Fairmont — Kevin L. Delli-Gatti, Patrick J. Forte, Robert F. Raspa and Robert A. Ringel; Mannington—Philip H. Horner; Worthington—Frank S. Veltri.

MARSHALL COUNTY: Moundsville—James E. Hurley.

MERCER COUNTY: Bluefield — Ellen K. Tabor.

MONONGALIA COUNTY: Morgantown — David J. Allison, Christopher A. Borchart, Padmini Chak, Leonard R. Coover, Brenda L. Holbert, Jane A. Kurucz, Eleanor K. Lowry, Ralph N. McDonald, Bertram D. Martin, Jeffrey A. Moore, Matthew D. Moore and Richard G. Snyder.

NICHOLAS COUNTY: Richwood—Richard A. Spencer; Summersville—Marvin L. Simons.

OHIO COUNTY: Wheeling—Veda L. Ackerman, Douglas E. Lemley, Steven E. Marks, Scott A. McNamara, Gregory S. Merrick, John M. Moore, Mark A. Myers, Ross S. Oliver, Mark J. Polak, Liane Sher.

PENDLETON COUNTY: Franklin—Jim H. Sponaugle and Marvin L. Sponaugle.

PRESTON COUNTY: Bruceton Mills—Mark R. Bennett.

RALEIGH COUNTY: Beckley — Charles R. Daniel, Donald H. Lee and William R. Sigmund.

RANDOLPH COUNTY: Elkins—Thomas R. Adamski.

TYLER COUNTY: Paden City—Michael E. Cunningham.

WEBSTER COUNTY: Hacker Valley—Basil L. Pugh.

WOOD COUNTY: Parkersburg—William H. Batten, Gina R. Busch and Mark D. Wass.

WYOMING COUNTY: Mullens — James S. Lewis.

OUT-OF-STATE: Connecticut — Douglas G. Althouse, New Canaan.

Conference On Elderly October 20-21

A conference, "Medical and Social Problems in the Elderly," will be held October 20-21 in Charleston under the sponsorship of the Kanawha Valley Family Practice Center.

The conference will begin Friday evening, October 20, with a keynote address by Richard Besdine, M. D., of the Hebrew Rehabilitation Center for Aging in Roslindale, Massachusetts. His address will be delivered in conjunction with a social hour and banquet on the fourth floor of the Medical Education Building at the Charleston Division, West Virginia University Medical Center.

The one-day session on Saturday will be held in the Education Building Auditorium, with registration to begin at 8 A. M. Dr. Marshall J. Carper of South Charleston will be moderator for the morning session.

The speakers and their topics will be:

"The Substance of Geriatric Medicine"—Doctor Besdine; "Emotional Problems in the Elderly"—Fred Charatan, M. D., Geriatric Psychiatrist, Jewish Institute for Geriatric Medicine, New York City; "Drug Therapy in Multi-Systems Disease"—John M. Hartman, M. D., Charleston; and "Surgery and Wound Healing"—James P. Boland, M. D., Charleston.

Dr. Jean P. Cavender of Charleston will moderate the afternoon session. Speaking will be Doctor Charatan, on "Sexuality in Old Age," and Dr. Margaret J. Albrink of the WVU School of Medicine in Morgantown, on "Nutrition in the Elderly."

The conference will close following a panel discussion beginning at 2:45 P. M., with the following speakers and topics:

J. L. Mangus, M. D., Charleston, "Eye and Ear Problems;" Dick Moran, R. P. T., Charleston,

"Mobility Problems;" George W. Hogshead, M. D., Nitro, "Urinary Problems," and John V. Merrifield, M. D., Dunbar, "Bowel Problems."

The course meets the criteria for credit toward Category 1 of the Physician's Recognition Award of the American Medical Association.

For registration and other information contact the Office of Continuing Education, Charleston Division, WVU Medical Center (phone 304-345-2600, ext. 242).

AAFP's Annual Meeting Set For San Francisco

Family doctors from all over the United States will convene in San Francisco this month to participate in one of the country's largest continuing medical education forums.

The event is the 30th annual AAFP Scientific Assembly and is sponsored by the American Academy of Family Physicians. The Academy represents the nation's family doctors and is the second largest medical organization in the country.

This year, the scientific program will be staged September 25-28 in San Francisco's Brooks Hall. The theme, "Family and Physician: Partners in Health," will focus on one of the specialty's primary goals —helping patients to care for themselves.

The AAFP was the first medical society to require its members to participate in continuing medical education. Each member must earn 150 hours of continuing medical education in order to maintain membership. Family doctors can accrue up to 30 CME hours in the three-and-one-half day scientific conclave. Nine program elements will be offered to participants.

The Congress of Delegates, governing body of the 41,000-member Academy, will convene prior to the Assembly to conduct official business. The 112 delegates will meet September 23-25 at the Fairmont Hotel, Assembly Headquarters. Participants will elect officers and present awards Monday, September 25.

Delegates from the West Virginia Chapter of the AAFP will be Drs. Del Roy R. Davis of Kingwood and Joseph A. Smith of Dunbar.

Seven-hundred family physicians will receive the degree of Fellow, AAFP, Tuesday, September 26, in the Masonic Auditorium. Following the ceremony, the new officers and members of the Board of Directors will be inaugurated. Dr. W. Jack Stelmach, Kansas City, will be installed as President.

Hal Wanger Family Practice Conference Program

The Fourth annual Hal Wanger Family Practice Conference will be held September 7-8 in Morgantown in the auditorium of the West Virginia University Medical Center.

The conference is sponsored by the Department of Family Practice, WVU School of Medicine; the WVU Office of Continuing Medical Education, and the West Virginia Chapter, American Academy of Family Physicians.

The speakers (WVU faculty members) and their topics for Thursday, September 7, will be "New Modalities in Diagnostic Radiology" — Orlando F. Gabriele, M. D.; "Differential Diagnosis of Generalized Weakness"—Ludwig Gutmann, M. D.; "Diagnosis and Treatment of Tuberculosis"—N. LeRoy Lapp, M. D.; "Salicylate and Acetaminophen Poisoning" — William G. Klingberg, M. D.; "Exercise Therapy for Painful Shoulders"—Sandy L. Burkhart, Ph.D.;

"Benign Gynecology" — John Foss, M. D.; "Management of Blunt Chest Trauma"—Herbert E. Warden, M. D., and "Incorporation—Benefit or Headache" — Dan Lambright (Management Consultant).

The Friday program will include:

"Diagnosis and Management of Prostatic Carcinoma"—Stanley J. Kandzari, M. D.; "The Cure of Childhood Leukemias" — Barbara Jones, M. D.; "Juvenile Rheumatoid Arthritis" — Anthony G. DiBartolomeo, M. D.;

"Drug Therapy for Dyspepsia" — Roland J. Weisser, Jr., M. D., and C. Wayne Weart, Pharm. D.; "Current Concepts in Infant Feeding," Barbara L. Tenney, M. D., and "Hypertension in Children"—William A. Neal, M. D.

Registration will be held both days at 8 A. M., with the scientific sessions beginning at 9 A. M.

Telephone Consultation Service Initiated At WVU

Consultation with West Virginia University Medical Center specialists will be only a phone call away for West Virginia physicians under a new program arranged by the WVU School of Medicine.

After a limited six-month trial run, the Patient Care Telephone Consultation Service has been extended statewide to all physicians, according to Robert L. Smith, M. D., Assistant Dean for Continuing Medical Education.

Doctor Smith said he expects the service, begun on August 1, to be especially helpful to physicians in the less heavily populated areas of the state.

A toll-free number, 800-352-2509, connects the calling physician with the Office of Continuing Medical Education, where personnel determine the nature of the consultation desired. Appropriate WVU faculty specialists return the call within two hours. The doctor who calls can obtain literature on the problem and can gain continuing medical education credit.

The toll-free number operates Monday through Friday from 8:30 A. M. to 4:30 P. M., holidays excepted.

Doctor Smith said the trial run covered 24 northern and eastern counties and the service proved especially popular with physicians in rural counties. One third of the calls came from National Health Service physicians who practice mainly in areas where medical facilities are limited.

62 Calls In 20 Weeks

During the initial test period, 62 calls were received in 20 weeks, with 34 directed to the Department of Medicine, including nine to Endocrinology, seven to General Medicine, six to Oncology and five to Infectious Diseases.

Doctor Smith said Surgery handled 11 consultations; Pediatrics, nine; Dermatology, three; Neurology, two, and Obstetrics, Pharmacology and Psychiatry, one each.

Doctors who used the service returned 23 evaluation forms and all said they found it of value and would probably use it again.

"Twenty-one felt more confident in managing their patient's problems, 12 had received information new to them, and 12 had actually changed their proposed management of the patient as a result of the consultation," Doctor Smith said.

He noted that many physicians already have established patterns of consultation with local colleagues and hospitals, and renewed ties with the University as well.

"But this new program was planned for those who aren't into those systems," he said. "It gives them a focal point, a place where they can call and get quick action.

"Doctors have always been able to call the Medical Center and get help, but they might not know what person to ask for, or how to find the best person as efficiently as possible. Our program can fill that gap."

Medical Meetings

Sept. 10-14—Am. Academy of Ophthalmology & Otolaryngology (Otolaryngology Section), Las Vegas.

Sept. 16-17—Am. Cancer Society, W. Va. Division, Inc., Annual Meeting, Canaan Valley State Park, Davis.

Sept. 19-21—Am. College of Emergency Physicians, Houston.

Sept. 21-23—Cardiology for the Clinician (Am. Heart Assn.), Williamsburg, Va.

Sept. 22-24—Am. Neurological Assn., Washington, D. C.

Sept. 26-28—Kentucky Med. Assn., Lexington.

Sept. 24-30—Am. College of Gastroenterology, Denver.

Sept. 25-28—AAFP, San Francisco.

Sept. 29-30—AMA Medical Staff Leadership Seminar, New York City.

Sept. 29-30—ASIM, Orlando, Fla.

Oct. 15-19—Am. Public Health Assn., Los Angeles.

Oct. 20-21—Am. Geriatrics Society, Baltimore.

Oct. 20-21—Medical & Social Problems in the Elderly (Kanawha Valley Family Practice Center), Charleston.

Oct. 21-25—Am. Society of Anes., Chicago.

Oct. 22-25—Indiana State Medical Assn., Clarksville.

Oct. 22-26—Am. Academy of Ophthalmology & Otolaryngology (Ophthal. Section), Kansas City, Mo.

Oct. 25-27—Cardiology Conference (Am. Heart Assn., University of Pittsburgh, W. Va. & Pa. Affiliates, AHA), White Sulphur Springs.

Oct. 25-29—Am. Academy of Child Psychiatry, San Diego.

Oct. 27-29—D. C. Medical Society, White Sulphur Springs, W. Va.

Oct. 30-Nov. 1—Pa. Med. Society, Lancaster.

Nov. 2-5—Med. Society of Virginia, Williamsburg.

Nov. 11-14—Southern Medical Assn., Atlanta.

Dec. 2-6—AMA Delegates Winter Meeting, Chicago.

Dec. 7-10—AMA Winter Scientific Session, Las Vegas.

1979

Jan. 26-28—12th Mid-Winter Clinical Conference, Charleston.

March 30-April 1—W. Va. Chap., AAFP, Charleston.

July 21-26—AMA Delegates Summer Meeting, Chicago.

Aug. 22-25—112th Annual Meeting, W. Va. State Medical Assn., White Sulphur Springs.

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WVU Medical Center
–News–

Compiled from material furnished by Mrs. Mary Ellin Wylie, Director, Medical Center News and Information Services, Morgantown, W. Va.

Hospital Staff, Department Appointments Announced

Barbara Jones, M.D., Professor and Assistant Chairman of Pediatrics, has been elected Chief of the West Virginia University Hospital Medical and Dental Staff. Doctor Jones, a member of the School of Medicine Faculty since 1961, also

Barbara Jones, M. D.

Robert S. McCuskey, Ph. D.

recently was named Chairman of the Neoplastic Disease Committee of the American Academy of Pediatrics.

In another major WVU staff addition, Robert S. McCuskey, Ph.D., a former Professor of Anatomy at the University of Cincinnati College of Medicine, has joined the School of Medicine Faculty as Professor and Chairman of the Department of Anatomy. John E. Jones, M.D., the WVU School of Medicine Dean, said that WVU "is fortunate to add to its faculty a person with such outstanding academic and research background."

The new Assistant Chief of Staff at WVU Hospital is N. LeRoy Lapp, M.D., Professor of Medicine in the Pulmonary Division. Secretary of Staff is Ellen Hrabovsky, M.D., Assistant Professor of Surgery and Pediatrics.

Representatives at large to the Executive and Credentials Committees are Juan F. Gutierrez, Associate Professor of Anesthesiology; William A. Neal, M.D., Associate Professor of Pediatrics and Chairman of Pediatric Cardiology; R. Stephen Amato, Associate Professor of Pediatrics; Phillip J. Peters, M.D., Assistant Professor of Medicine, and Ronica M. Kluge, M.D., Associate Professor of Medicine and Chairman of the Infectious Diseases Division.

Native of Cleveland

Doctor McCuskey, who was born in Cleveland, began teaching in Cincinnati in 1965 after receiving his doctorate in anatomy at Western Reserve University.

An expert on the microvascular system, he was recipient from 1969 to 1974 of a National Institutes of Health Research Career Development Award. His current study of hepatic microvascular regulatory mechanisms is funded by the American Heart Association, Inc. and the National Heart, Lung and Blood Institute which also funds his research on cerebral diabetic microangiopathy and his study of the hemodynamics of sickle cells in the microcirculation.

Among his other research and teaching interests are experimental hematology, specialized methods of microscopy, and application of television and electronic techniques including the production of teaching films and videotapes illustrating functional microscopic anatomy of living cells, tissues and organs.

Author or co-author of more than 80 publications and several scientific motion pictures, McCuskey has been an invited speaker and lecturer frequently in this country and also in England, Switzerland, Belgium, West Germany and The Netherlands.

He serves as Associate Editor of "Microvascular Research" and is a member of many scientific groups including the Basic Science Council of the American Heart Association, the American Association of Anatomists, the Microcirculatory Society and its European counterpart, the American Society for Hematology and the International Society for Transport of Oxygen to Tissue.

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Third-Party News, Views and Program Concerns

Compensation Law Changes Affect Medical Practice

The 1978 West Virginia Legislature enacted several amendments to the Workmen's Compensation Statute, effective as of July 1. Two of these changes are of special importance to the medical community.

One provides for the payment of medical bills during litigation. Formerly, medical vendors were not notified of the payment or rejection of any medical bills submitted for a protested claim until the litigation of that claim was resolved. These medical bills now are being processed the same as other bills, regardless of any litigation involved.

Medical invoices pending because of claims protested prior to July 1, 1978, will be considered for payment as well. Approximately $77,000 in medical bills will be paid because of the retroactive administration of this law.

The second major change permits a physician to release medical information directly to the employer. The new language states that a claimant agrees, by filing an application for benefits, that any physician may release to the claimant's employer or the employer's representative medical reports containing detailed information as to the claimant's condition, treatment, prognosis and anticipated period of disability. The physician also may release to the employer dates as to when the claimant will reach or has reached maximum degree of improvement, and will be or was released to return to work.

Congress Stuns Administration On Cost Containment

The Carter Administration was dealt a second severe blow on the hospital cost control issue when the U. S. Senate's Finance Committee tentatively approved a measure to change Medicare-Medicaid reimbursement of hospitals without including any of the Adminstration's proposals to broaden the bill.

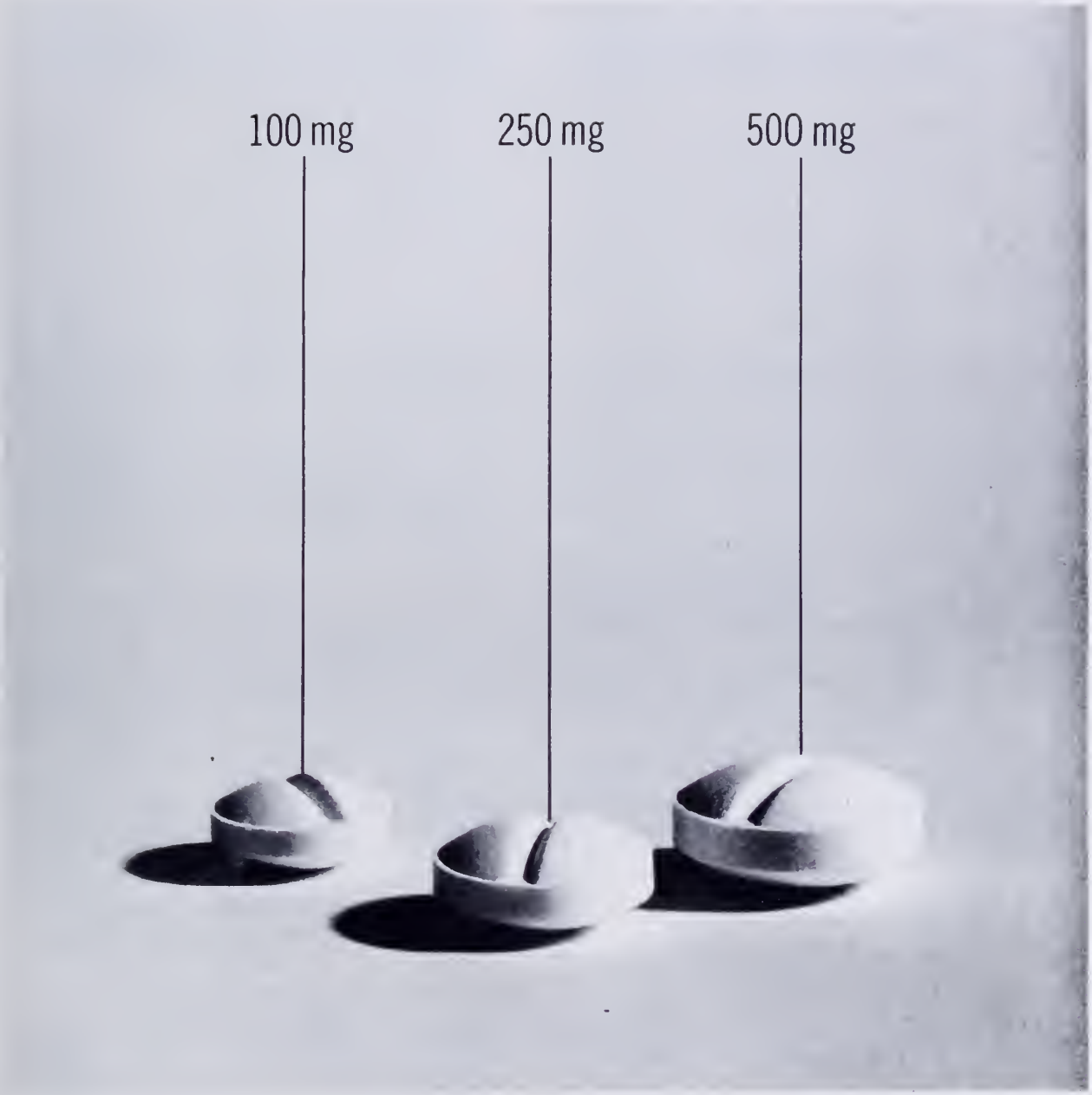
A few days earlier, in mid-July, the House Committee on Interstate and Foreign Commerce had stunned the Administration by removing the threat of federal controls from its bill. Referring to the Commerce Committee Action, Robert B. Hunter, M.D., Chairman of the American Medical Association's Board of Trustees and Co-Chairman of the current Voluntary Effort Program, said:

"The AMA is pleased to learn that the efforts of the private sector, through the Voluntary Effort and other cost-consciousness programs, have been recognized by Congress. This kind of coordinated and cooperative effort . . . is the only responsible approach to the continued delivery of quality health care." The Voluntary Effort is being conducted by the AMA, the American Hospital Association and the Federation of American Hospitals.

In a telegram to state medical society officials, Executive Vice President James H. Sammons, M.D., of the AMA said: "The stunning defeat administered President Carter's hospital cost control legislation by the House Commerce Committee is a tribute to the joint AMA-hospital associations' Voluntary Effort, other cost-awareness programs by physicians and hospitals, our Washington Office and the splendid cooperation of state medical societies."

The bill approved by the Commerce Committee would ask hospitals to cut revenue increases by two per cent a year and establish a Presidential Commission to oversee the situation. HEW Secretary Joseph Califano said the Administration "lost to a very strong and effective lobby." He said he would "assess our ability to obtain a meaningful bill from Congress this year" and, if this can't be done, take the case "to the people and come back next year with a strong proposal."

Further action on the Senate bill was pending at this writing.



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Obituaries

UPSHUR HIGGINBOTHAM, M. D.

Dr. Upshur Higginbotham of Bluefield died in St. Luke's Hospital there July 23. He was 68.

A native of Charleston, Doctor Higginbotham was a graduate of Greenbrier Military Academy, West Virginia University and the Medical College of Virginia in Richmond. He was a former Chief of Staff at St. Luke's.

Doctor Higginbotham served an internship at the Jersey City, New Jersey, Medical Center, and an internship and residency at MCV. He practiced in Roanoke Rapids, North Carolina, and in Montgomery, West Virginia, before settling in Bluefield.

A specialist in internal medicine, Doctor Higginbotham was an honorary member of the Mercer County Medical Society, of which he served as President in 1949; the West Virginia State Medical Association, and the American Medical Association.

He was active in State Medical Association affairs, serving as a member of the Committee on Insurance at the time of his death.

Doctor Higginbotham is survived by his widow; three sons, Upshur, Jr., of Shady Spring, John T. of Pittsburgh and Henry K. of Pulaski, Virginia; a daughter, Mrs. Richard Lee Gibson of Nashville, Tennessee; a sister, Mrs. Mary Catherine Adams of Kingsport, Tennessee, and a brother, Henry K. Higginbotham.

* * *

GEORGE F. PUGH, JR., M. D.

Dr. George F. Pugh, Jr., of Martinsburg, Medical Director for the Berkeley-Morgan County Health Department, District 6, for the past seven years, died on June 25 in a hospital there. He was 55.

Doctor Pugh had been in general practice in Martinsburg since 1952.

Born in Terra Alta, he was a graduate of Charleston High School and West Virginia University, receiving his medical degree in 1951 from Cornell University Medical College. He interned in Grand Rapids, Michigan.

A veteran of World War II, Doctor Pugh was an honorary member of the staff of City and King's Daughters hospitals in Martinsburg and a former consultant for the Eastern Panhandle Mental Health Department.

(Continued on page xviii)

County Societies

CENTRAL WEST VIRGINIA

The Central West Virginia Medical Society met May 4 at Sutton Lane Hotel in Sutton to hear an interesting presentation by Dr. Greenbrier Almond of Buckhannon on geriatric psychiatry.

During its business session, the Society approved an effort to obtain fluoridation for public water supplies in the Society area not now so covered. It discussed additional matters including continuing medical education programs in the area; new United Mine Workers contract provisions related to health care, and a proposal for a Wood-Johnson Foundation funded school health program in Calhoun, Gilmer, Doddridge and Ritchie counties.—Joseph B. Reed, M.D., Secretary.

* * *

FAYETTE

The Fayette County Medical Society met on June 7 at the Oak Hill (West Virginia) Hospital.

The film, "Management of Angina Pectoris," a description primarily of the use of Inderal in the management of coronary insufficiency, was shown.

Following the film, Dr. Chuan H. Lee of Montgomery gave a paper on roentgenography diagnosis of gout. He gave an excellent discussion of the differential diagnosis and features of similar diseases both from an x-ray and clinical standpoint.—Joe N. Jarrett, M. D., Secretary.

* * *

TYGART'S VALLEY

The Tygart's Valley Medical Society met on May 18 at the Tygart Valley Lodge in Grafton.

The program was presented by Dr. Robert H. Waldman, Chairman, Department of Medicine, West Virginia University School of Medicine, Morgantown. He spoke on "Treatment of Viral Disease," covering viral respiratory infections, including influenza, and various medications and treatment. He also discussed herpes simplex and herpes zoster and treatment. (Note: The above was submitted by Karl J. Myers, Jr., M. D., Acting Secretary.)

The Society met in conjunction with its 29th Annual Post Graduate Session (See program in the June issue of the *Journal*) on June 15th at the Elks Country Club in Elkins. Approximately 80 members and guests attended.—A. Kyle Bush, M. D., Secretary.

Book Review

CURRENT PEDIATRIC DIAGNOSIS & TREATMENT, 5TH EDITION — C. Henry Kempe, M. D.; Henry K. Silver, M. D.; and Donough O'Brien, M. D. Lange Medical Publications, Los Altos, California 94022. 1,102 Pages. 1978. Price $17.

This is the Fifth Edition of a paperback textbook which was first published in 1970. It meets the need for a current textbook of pediatrics. Descriptions of conditions are thorough and practical. The emphasis is on early diagnosis of important diseases, preventive medicine, and family counseling. Contributors are on the staff of the University of Colorado Medical School.

The *Handbook on Pediatrics* also is issued every second year by Silver, Kempe, and Bruyn. —Lois E. Pfister, M. D.

HANDBOOK OF PEDIATRICS, 12TH EDITION — Henry K. Silver, M. D.; C. Henry Kempe, M. D., and Henry B. Bruyn, M. D. Lange Medical Publications, Los Altos, California 94022. 723 Pages. 1977. Price $9.

The *Handbook of Pediatrics* was first published in 1955. Its success is attested to by its continued popularity through 11 previous editions and five current editions in various foreign languages. It has been updated every two years since its first publication.

In undertaking this review I spent an evening browsing through the 32 chapters and was pleased with what I saw. The material is concise and clear. The tables are well organized and appropriate for the clinician. Considering the relatively long history of wide acceptance of this handbook, one would be hard put to report adversely on its contents. To be more thoroughly acquainted with its actual usefulness it was put to a further test. For a full month of daily pediatric teaching ward rounds with pediatric residents, family practice residents, as well as third- and fourth-year medical students, the handbook was frequently consulted. Useful information was always at hand. Its practical use as a supplement to complete pediatric texts and current literature was emphasized. Since our rounding group included third- and fourth-year medical students, the chapter on pediatric procedures (32) was especially useful as these procedures were demonstrated. The drug dosage list was also helpful.

The individual sections undoubtedly prepared by many different authors were not disjointed or unbalanced. I closely scrutinized the sections I felt would be most frequently used by me.

Epilepsy was succinctly covered and the table of anticonvulsant drugs was accurate and up-to-date. Maximum doses were listed and that is a useful limit to place where the principal users of the book will be house officers. Pediatric neurologists have more advanced skill, and with careful monitoring at their disposal, may feel differently about what seems to be restrictive limits. The approach to the subject of Emotional Problems was family-oriented as is proper to the pediatric philosophy of management. The coverage was complete, and I believe this to be one of the best sections for a quick review of the subject. Even in this format Mental Retardation is too briefly covered, admitting my own special interest is biased towards a fuller consideration of this important subject.

Further review included an attempt to use a section of the book covering material with which I have become "rusty." Hematology filled the bill and I found the section helpful as hematologic problems presented. Brief and useful classification of hemophilia, DIC, purpuras, ITP, anemias, along with clinical signs and treatment put one on the right track quickly.

Finally, the *Handbook of Pediatrics* is a very practical book which may be advantageously used by the general pediatrician, the family physician, as well as house officers in these disciplines. The pediatric nurse practitioner may also find it very useful. Overall, the book gets high marks in its category.—Thomas G. Potterfield, M. D.

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OBITUARIES—Continued from page xvi

He was a member of the Eastern Panhandle Medical Society, the West Virginia State Medical Association and the American Medical Association.

Survivors include the widow; two daughters, Miss Paula Pugh, Silver Springs, Maryland, and Mrs. Freddie Smeltzer, Jr., of Martinsburg, and the parents, Mr. and Mrs. George F. Pugh of Clearwater, Florida.

* * *

RUPERT W. POWELL, M. D.

Dr. Rupert W. Powell, retired Fairmont radiologist, died on July 31 in a hospital there. He was 73.

A native of Morgantown, Doctor Powell came to Fairmont in 1949. He served as Chief of the Radiology Department at Fairmont General Hospital until 1958, when he entered private practice of radiology in the Professional Building, practicing there until his recent retirement.

He was graduated from West Virginia University and received his M. D. degree in 1935 from the Medical College of Virginia. He interned at Shenandoah Hospital in Roanoke, Virginia, and was in general practice in Roanoke until 1941, when he began service with the U. S. Army Medical Corps, continuing through 1946.

After his military service, Doctor Powell completed a residency in radiology at the Medical College of Virginia and McGuire Veterans Administration Hospital in Richmond.

Doctor Powell was a Diplomate of the American Board of Radiology, a retired member of the American College of Radiology, a member of the Radiological Society of North America and a Past President of the West Virginia Alumni Chapter of the Medical College of Virginia.

He was an honorary member of the Marion County Medical Society, the West Virginia State Medical Association and the American Medical Association.

Survivors include the widow, and two sisters, Mrs. Earl Renner of Morgantown and Mrs. Guy Currence of Napier.

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The West Virginia Medical Journal

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MEMBER, WEST VIRGINIA PRESS ASSOCIATION, 1978

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The West Virginia Medical Journal

Vol. 74, No. 10 October, 1978

Management Of Testis Tumors

JOHN A. BELIS, M. D.
STANLEY J. KANDZARI, M. D.
D. FRANKLIN MILAM, M. D.
Division of Urology, West Virginia University Medical Center, Morgantown.

Significant advances continue to be made in the management of testicular tumors. An aggressive multidisciplinary approach is necessary for optimum management. Careful attention must also be devoted by all physicians to the scrotal examination, particularly in young men, as every testicular mass should be considered a potential tumor. In addition to therapeutic advances, improved survival may be obtained through early diagnosis and proper initial management.

Recent developments in the management of germ cell tumors of the testis have altered the course of this once highly lethal group of malignancies. Advances in diagnostic methods, radical surgery, chemotherapy, and radiation therapy, and in particular the combination of these modalities in a multidisciplinary approach have markedly improved five-year survival and complete remission rates in patients with Stage II and Stage III disease. However, delay in diagnosis and occasional mismanagement of patients with testicular tumors continue to be serious inhibitory factors in improving survival statistics further. The multidisciplinary approach to testicular tumors will be discussed along with common problems in diagnosis and management. Patients who have presented prior to 1975 at West Virginia University Medical Center with these tumors will be reviewed with particular attention to initial presentation and ultimate survival.

TABLE 1

Clinical Staging of Testis Tumors

Stage I	– tumor confined to one testis without evidence of metastases
Stage II	– clinical or radiologic evidence of metastases to the femoral, inguinal, iliac, or para-aortic lymph nodes below the diaphragm
Stage III	– metastases above the diaphragm or to any other distant body organ

The incidence of germ cell tumors of the testes is approximately 2.2 per 100,000 males, and they are the most common solid tumors in males age 15-34.[1] These tumors may be subdivided into seminomas and carcinomas (embryonal carcinoma, teratocarcinoma, and choriocarcinoma)

Figure 1. Normal lymphangiogram.

and often present as mixed-cell types. Testis tumors are divided into three stages as presented in Table 1.[1] Current approach to this malignancy following initial presentation offers an aggressive diagnostic and therapeutic regimen.

Diagnostic Methods

Intravenous pyelography. This study aids in evaluation of retroperitoneal lymph nodes. Tumor involvement may frequently cause ureteral displacement, renal displacement, or ureteral obstruction with hydronephrosis and eventual non-functioning renal unit.

Lymphangiography. Despite inherent diagnostic inaccuracies, bilateral lower extremity lymphangiography provides a great deal of important information concerning involvement of retroperitoneal lymph nodes by tumor.[2] In addition, lymphangiography assesses the completeness of lymphadenectomy, aids in localizing radiation therapy, and may reveal response to initial treatment during the period in which lymph nodes remain opacified. Examples are presented of normal retroperitoneal lymph nodes (Figure 1), lymph nodes with multiple abnormal filling defects (Figure 2), and a large retroperitoneal mass causing lymphatic obstruction and displacement of right kidney and right ureter (Figure 3).

Chest tomography. Whole-chest tomography is mandatory in staging, as many pulmonary lesions may be discovered in this manner prior to their appearance on plain chest x-ray. This technique also provides a means of evaluating and following chemotherapeutic response.

Figure 2. Abnormal lymphangiogram demonstrating filling defect in right iliac lymph nodes.

Figure 3. Lymphangiogram demonstrating large retroperitoneal mass obstructing lymphatics and displacing right kidney and ureter.

Liver scan. This procedure is of limited value but it occasionally may be a positive indicator of Stage III disease.

Inferior vena cavagram. Cavography may help in evaluating the extent of very large retroperitoneal mass lesions, and assist the surgeon in intraoperative handling of the vena cava. An example is presented of a vena cavagram demonstrating complete obstruction of the inferior vena cava with extensive dilatation of collateral veins (Figure 4).

Urinary HCG. This measurement of gonadotropin production is helpful in assessing prognosis and response to therapy when positive.[3]

Serum alpha-fetoprotein and serum beta-HCG. Extremently sensitive radio-immunoassays for these protein markers have provided a means for accurate assessment of response to therapy.[4]

Treatments of Choice

Surgery:

In the treatment of seminomas, initial surgery is inguinal orchiectomy with high ligation of the spermatic cord. As seminomas are highly

Figure 4. Obstruction of left iliac vein and vena cava.

radiosensitive, further surgery is not usually indicated.

With other germ cell malignancies, further surgery is indicated, primarily radical retroperitoneal lymphadenectomy including suprarenal lymphatic dissection.[5] Inguinal lymphadenectomy and hemiscrotectomy should be performed when indicated, particularly if there has been prior violation of the scrotal skin.[6] The surgeon should also aggressively remove tumor bulk and residual local disease as chemotherapy of germ cell tumors appears to be more effective when tumor bulk is reduced. At all times the area of tumor resection should be outlined with silver clips to assist and evaluate later radiation therapy or chemotherapy. A scalene node biopsy is performed by some authors[7] in Stage II disease as a small percentage of these patients are thus found to have Stage III disease.

Radiation Therapy:

Radiation is the treatment of choice in seminomas when disease is localized.[8] Use in nonseminomas is controversial. It may be beneficial in treatment of areas of residual tumor[9] and either before or after retroperitoneal lymphadenectomy.[10]

Chemotherapy:

Many chemotherapeutic agents are known to be active in testicular tumors, and combination of these agents in recent years has significantly improved remission rates and incidence of complete remissions.[11-14] Some agents which have been useful include actinomycin-D, vinblastine, vincristine, bleomycin, adriamycin, platinum, cytoxan, methotrexate, and 5-fluorouracil.

Ideally, the treatment of germ cell malignancies should be approached in a multidisciplinary fashion allowing the surgeon, radiation therapist, and chemotherapist to arrange treatment of the individual patient according to the modalities outlined above. Such regimens should be initiated and maintained at centers where all necessary diagnostic and therapeutic measures are available. Surgery must be aggressive, often extensive, and as complete as possible, while radiation and chemotherapy involve considerable toxicity and require careful monitoring.

In contrast, delay in diagnosis and occasional poor initial handling continue to diminish the survival rate in testicular malignancies. The physician must avoid oversight in genital examinations, particularly in young men, and treat all testicular masses as tumors until proven otherwise.

A review of germ cell tumors of the testis presenting before 1975 at West Virginia University Medical Center according to survival is presented in Table 2. Fifty per cent of all patients

TABLE 2

Testicular Tumors at West Virginia University Hospital According to Survival (minimum three-year follow-up)

Stage	*Number at Each Stage*	*Overall Survival*	*Survival Seminomas*	*Survival Non-seminomas*
I	21	90%	11/12	8/9
II	12	75%	5/5	4/7
III	9	22%	0/1	2/8
Total—all stages	42	71%	16/18	14/24

with testicular tumors had metastases at the time of diagnosis. This correlated closely with the large series at Walter Reed General Hospital.[15] Twenty-one patients presented with Stage I tumors with overall survival of 90 per cent in that subgroup (19 patients alive>3 years after diagnosis).

In the group of patients presenting with Stage II tumors, overall survival has been 75 per cent (9 patients alive>3 years after diagnosis). Aggressive therapy by retroperitoneal surgery, chemotherapy, and radiation therapy has produced a marked improvement in survival statistics in this group in recent years. In contrast, overall survival of patients with Stage III lesions was only 22 per cent (only 2 patients alive>3 years in complete chemotherapeutic remission). Therefore, it appeared that delay in diagnosis was associated with an associated diminished prognosis. As noted in other reports,[12,13] survival was much better at Stages I and II for patients with seminomas than for patients with non-seminomatous tumors. However, survival for Stage II and Stage III non-seminomatous germ cell tumors has improved considerably in recent years through a combination of radical surgery and chemotherapy.[15]

Problems in initial management prior to presentation at West Virginia University Medical Center were most commonly associated with scrotal contamination (Table 3), either by direct exploration or needle aspiration. Violation of the scrotum should be strictly avoided in all testicular masses as alteration in lymphatic drainage will occur, allowing metastases to the inguinal region and abdominal wall. All cases known to have a contaminated scrotum, including cases with previous orchiopexy for cryptorchidism, should also be treated with hemiscrotectomy and ipsilateral inguinal lymphadenectomy. Five of the seven cases in Table 3 developed proven inguinal lymph node metastases and three are now deceased.

TABLE 3

Problems in Initial Management of Testis Tumors Prior to Presentation at West Virginia University Hospital

Transcrotal Removal of Tumor	2
Inguinal Metastases Following Orchiopexy	2
Biopsy of Tumor Without Excision	1
Needle Aspiration	1
Biopsy of Abdominal Mass in Presence of Testicular Mass	1
Total/Total Cases	1/42

Two cases in this series were known to have prior orchiopexy for cryptorchidism in which germinal malignancies developed in the cryptorchid testes (Table 3). In both cases metastases developed in the ipsilateral inguinal lymph nodes. Cryptorchid testes should be examined periodically following orchiopexy because of a higher incidence of malignancy in these organs.[1] Another patient in this series had previous ipsilateral scrotal violation for hydrocele repair 13 years prior to diagnosis of testis tumor. Both ipsilateral inguinal lymphadenectomy and retroperitoneal lymphadenectomy were negative for metastases.

Summary

In summary, significant advances continue to be made in the management of testicular tumors. An aggressive, multidisciplinary approach is necessary for optimum management. Careful attention must be devoted by all physicians to the scrotal examination, particularly in young men. Every testicular mass should be considered a potential tumor and approached aggressively. Problems with initial management as noted above should be avoided. In addition to therapeutic advances, improved survival may be obtained through early diagnosis and proper initial management.

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Where reference is made to generically-designated drugs, the first such reference must be followed by parentheses containing the most commonly known trade-name drug of that designation. In addition, a listing of all generic drugs mentioned in the article, with their trade-name equivalents, should appear at the end of the article.

A short abstract summarizing the manuscript should be included. This should be typed in double space on a separate page.

Authors are requested to submit a carbon copy with the original.

Illustrations should be numbered and their approximate locations shown in the text. Each should be identified by placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for reproduction should be done in black (India) ink on pure white. Photographs should be on glossy paper and minimum of about 5 by 7 in. in size. A legend should be provided for each illustration and, preferably, attached to it.

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Peripheral Gangrene And Coagulopathy In A Splenectomized Hodgkin's Disease Patient

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A 25-year-old patient who underwent staging laparotomy and splenectomy for Hodgkin's disease developed pneumococcal meningitis, disseminated intravascular coagulation (DIC) and gangrene of the toes. A possible mechanism for increased susceptibility to pneumococcal infection is discussed. The risk of developing life-threatening infections after splenectomy exists even in adults and should influence our decisions to make use of splenectomy in staging procedures.

THOUGH the risk of postsplenectomy infection in the pediatric age group has been well emphasized,[1,2,3] a high incidence of life-threatening infection may be present even when splenectomy is carried out in adulthood.

We report a 25-year-old patient who underwent staging laparotomy as a part of diagnostic evaluation and developed life-threatening pneumococcal meningitis, disseminated intravascular coagulation (DIC) and bilateral peripheral gangrene of the toes one year after splenectomy, when he was symptom-free of the disease.

Case

A 25-year-old white male was admitted to Veterans Administration Hospital, Allen Park, Michigan, with a two-day history of diarrhea, fever and generalized weakness. The patient had been known to be a paraplegic since 1968 after a helicopter accident in Vietnam. During a routine dental checkup, a submandibular lymph node was noted to be enlarged which, on biopsy, revealed Hodgkin's lymphoma, lymphocytic predominance. Subsequently, the patient underwent staging laparotomy with splenectomy. The speen weighed 125 grams, and multiple histological sections were negative for lymphoma. Clinical and pathological staging was 1A. He was treated with a full course of mantle and inverted Y radiotherapy. The patient remained asymptomatic during the following two-year period.

At the time of admission to our hospital, the physical examination revealed a temperature of 101°F, a pulse rate of 100/min. and a normal blood pressure of 120/80 mm Hg. Examination of ear, nose and throat was normal. His lungs were clear to auscultation and percussion. His dorsalis pedis and posterior tibial pulses were equally strong and palpable. The deep tendon reflexes were exaggerated on both sides and there was a bilateral Babinski response. The chest x-ray film was within normal limits.

During the first six hours of hospitalization, the patient developed a severe headache and vomiting. A lumbar puncture was performed which showed opening and closing pressures of 360 mm. and 240 mm. of CSF. Analysis of cerebrospinal fluid revealed: protein, 306 mg.; sugar, one mg. (blood sugar, 140 mg.); total cell count, 201/cu.mm. with a differential of 70 per cent polymorphonuclear and 30 per cent mononuclear cells. A gram stain of CSF showed a large number of gram positive diplococci. Aqueous crystalline penicillin at a dosage of 2 million units intravenous every two hours was started after obtaining blood and sputum cultures. Subsequently, the blood and CSF cultures were positive for streptococcus pnuemoniae.

During the first 12 hours, the appearance of bilateral dark purple mottling of toes was noted (Figure). Initial coagulation studies were as follows: Prothrombin time, 14 secs. (control, 11.0 secs.); partial prothrombin time, 41 secs.

Figure. Peripheral gangrene of the toes.

(control, 25 secs.); platelet count, 140,000; and fibrinogen, 250 mg. and positive fibrin split products. Occasional schistocytes were seen in the peripheral blood.

Subsequently, the x-ray films of mastoid and paranasal sinuses were normal. Intravenous penicillin was continued with monitoring of CSF protein and sugar along with other coagulation parameters. No further extension in skin lesion was noted after initiation of penicillin therapy. Over the next several days, a gradual increase in CSF sugar and decrease in CSF protein were noted. The platelet count rose to 620,000 and fibrinogen level to 800 mg. On the eighth day of admission, the patient had generalized seizures for which he was treated with phenobarbital and dilantin. During the second week of admission he also developed loss of hearing, more so on the right side. Penicillin therapy was continued for three weeks.

Three weeks after recovery from the sepsis, he was reevaluated with no clinical evidence of recurrence of Hodgkin's disease noted. Serum immunoglobulins were normal as well as the study of peripheral blood lymphocytes (number of T and B lymphocytes) and their response to phytohaemagglutinin and pokeweed was normal. The patient had positive skin test for mumps and candida.

Comments

The salient feature of this case was bacteremia with a rapid onset of symptoms which has been reported earlier in overwhelming postsplenectomy infection (syndrome of OPSI), and DIC as evidenced by an elevated thrombin time, prothrombin time, decreased platelet count and presence of fibrin split products and peripheral gangrene of the toes. The patient was not hypotensive during this period. The presence of "normal" fibrinogen level could be attributed to infection.

Whitaker and Bisno have described several cases of pneumococcal infection in people who have no spleen, with Waterhouse-Fridericksen syndrome or the presence of clinical and laboratory evidence of DIC.[4,5] The clinical description of our patient fits the above-mentioned syndrome (OPSI). Pneumococci exert several dose-dependent thromboplastic effects *in vitro* by release of thromboplastic substances.[6] Also, pneumococcal capsular polysaccharides could directly damage the capillary endothelium with the formation of platelet thrombi and initiation of clotting. Normally, the spleen acts as a filter for removal of foreign particles (capsular polysaccharides) and loss of this clearing function may play an important contributory role in producing intravascular coagulation in the postsplenectomy state.[7,8]

The presence of peripheral gangrene associated with intravascular coagulation has been reported in pneumococcal bacteremia.[9,10] The clinical course of postsplenectomy infection is rather well characterized by about 80 per cent of the infection occurring in the first two years after splenectomy. A higher incidence has been noted with underlying disorders such as lymphoma.[11,12] The onset of symptoms is abrupt and fulminating and may be fatal in hours if unrecognized. In overwhelming infection, the initial CSF examination may show an absence of polymorphonuclear response, and the appearance of the CSF could be cloudy due to a large number of organisms. The microorganism is usually M. Streptococcus Pneumoniae or Hemophilus Influenzae.

Though immediate postoperative complications after staging laparotomy and splenectomy vary from different medical centers, there is generally a low incidence.

With the use of any new modality of treatment and diagnostic procedure the long-term effects and benefits of the procedure should be weighed against the risk involved. Development of serious infection as late sequela of staging laparotomy should be kept in mind.

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Medical Practice Economics Reference

THE seventh annual edition of the American Medical Association's *Profile of Medical Practice* is off the press, with 283 pages of new information on the economics of medical practice in the United States today.

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Assessment Of X-Ray Pelvimetry In The Management Of Labor

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There has been increasing concern about the effects of radiation exposure of the human fetus in utero.[1,6,9,11,12] *There has also been increasing emphasis on the quality, rather than the quantity, of human reproduction. Thus, it is important to reevaluate the role of diagnostic radiologic procedures in the care of the parturient.*

The role of x-ray pelvimetry is a controversial one. Some have condemned the procedure as unnecessary and possibly harmful.[5,8,10,11] *Others consider it indispensable.*[16]

This study was undertaken to assess the value of x-ray pelvimetry in the care of patients in a community hospital, the Ohio Valley Medical Center in Wheeling, West Virginia.

THE records of 200 patients who had x-ray pelvimetry in the Ohio Valley Medical Center in Wheeling, West Virginia, were studied. The only information analyzed was x-ray results, outcome of labor, and information sufficient to plot a partogram. Factors such as position and presentation, age, race, parity, social or economic status, and private or nonprivate patient category were not considered.

The x-ray pelvimetry was carried out using a modified Thoms technique plus a flat plate of the abdomen to assess fetal position. The anterior-posterior and transverse diameters of the pelvic inlet and midplane were converted to pelvic capacity using the Mengert formula.[7] Patients with a pelvic capacity below 80 per cent in any of the above planes were considered to have an inadequate pelvis. Those with a capacity between 80 per cent and 90 per cent were termed borderline. A patient with a pelvic capacity of above 90 per cent was rated as having an adequate pelvis.

The partograms were reviewed as well. They were classified as normal, primary dysfunctional labor, secondary arrest of dilatation, and failure to descend in accordance with Friedman's criteria.[3,4] The predominant pattern was the main consideration when any patient displayed more than one abnormal pattern.

Labor patterns were then compared to pelvic capacity and the outcome of labor. Another correlation was made between pelvic capacity and outcome of labor.

Results

A total of 200 patients had x-ray pelvimetry studies. Twelve patients had the x-ray studies done before admission to the Labor and Delivery Unit, while the remainder had the pelvimetry performed during their stay in the Unit. Three of the 12 patients noted were not permitted to labor. All three were found to have adequate pelvic capacity; however, they underwent Cesarean section for unrelated reasons. The remaining nine patients of this group did go in labor subsequently.

The pattern of labor in these patients is summarized in Table 1. Dysfunctional labor of some type occurred in 119 of the 197 patients who were observed. The results of x-ray pelvimetry by pelvic capacity are denoted in Table 2. Only 15 per cent of the patients were considered to have inadequate or borderline pelvic capacity.

The methods of delivery are summarized in Table 3. The rates for Cesarean section and mid-forceps should be compared to the overall rate in this hospital of 14.7 per cent and 5.7 per cent respectively.

The pattern of labor and outcome are listed in Table 4. Of the 78 patients with a normal pattern of labor, only six had Cesarean section and two had mid-forceps delivery. Dysfunctional labor was observed in 119 patients. In this group only 21 per cent (25 patients) eventually had either a normal delivery or were assisted with low forceps. The remainder resulted in Cesarean section (77 patients or 65 per cent) and mid-forceps delivery (17 patients or 14 per cent).

The pattern of labor is correlated with the findings of x-ray pelvimetry in Table 5. Only seven of the 30 patients considered to have a borderline or inadequate pelvis displayed a normal pattern of labor. In the 170 patients with adequate pelvic capacity, it is to be recalled that three were not permitted to labor. In the remaining 167 patients, dysfunctional labor occurred in 57.5 per cent (96 patients).

The findings on x-ray pelvimetry are matched with the method of delivery in Table 6. Cesarean

sections were performed on 66 patients considered to have adequate pelvic capacity. This represented 39 per cent of all patients determined to have adequate pelvic capacity by x-ray pelvimetry.

As a result of this analysis the following were noted:

1. On the basis of x-ray pelvimetry, only 30 of the 200 patients were considered to have borderline or inadequate pelvic capacity.

TABLE 1
Pattern of Labor

No labor	3
Normal labor	78
Primary dysfunctional labor[1]	56
Secondary arrest of dilatation[2]	43
Arrest of descent[3]	20
Total	200

1—PDL
2—SAD
3—AOD

TABLE 2
Pelvimetry Results

Adequate	170
Borderline	26
Inadequate	4
Total	200

TABLE 3
Mode of Delivery

C-section, no labor	3	
		43%
C-section, with labor	83	
Mid-forceps	19	9.5%
Low forceps	43	21.5%
Normal delivery	52	26%
Total	200	

2. In the 30 patients, 23 had dysfunctional labor and 20 were delivered by Cesarean section.
3. In the remaining 170 patients with adequate pelvic capacity, 96 had dysfunctional labor culminated by Cesarean section in 63 of this group of patients.
4. There appears to be a high correlation between partographic dysfunctional labor and outcome as frequently mentioned by Friedman.[3,4]
5. The use of x-ray pelvimetry prior to adequate, active labor does not seem to add sufficient information to alter significantly further management of the patient.

Discussion

Russell and Richards made a comparison between x-ray measurements noted in 833 patients with suspected cephalopelvic disproportion and the findings in 110 women who had x-rays taken for assessment of fetal maturity.[10] They could not discern any difference in pelvic size in both groups. Yet the incidence of operative delivery in patients referred for pelvimetry was higher. Cesarean sections were done in 244 of the 833 patients. This produced a rate of 29 per cent, approximately 3.5 times the overall Cesarean section rate of 8.6 per cent for the hospital. The mean fetal weight of babies born by Cesarean section was lower than in babies who delivered vaginally.

The same authors theorized that when an obstetrician seeks x-ray pelvimetry on a patient, it is not necessarily because the patient has a small pelvis. It is probably because he suspects the patient may have problems in labor. This appears to be confirmed in our review of 200 patients who had x-ray pelvimetry.

Hannah has reported a retrospective study of 300 patients who had x-ray pelvimetry.[5] The

TABLE 4
Pattern of Labor and Delivery Method

	NSD	*Low Forceps*	*C-Section*	*Mid-Forceps*	*Total*
No labor	0	0	3	0	3
Normal	41	29	6	2	78
P.D.L.	8	8	37	3	56
S.A.D.	1	5	34	3	43
A.O.D.	2	1	6	11	20
Total	52	43	86	19	200

TABLE 5
Pattern of Labor and X-ray Pelvimetry

	No Labor	*Normal*	*PDL*	*SAD*	*FD*	*Total*
Adequate	3	71	44	34	18	170
Borderline	0	6	10	8	2	26
Inadequate	0	1	2	1	0	4
Total	3	78	56	43	20	200

TABLE 6
X-ray Pelvimetry and Delivery Method

	NSD	*LFD*	*MFD*	*C-Section*	*Total*
Adequate	49	38	17	66	170
Borderline	3	4	2	17	26
Inadequate	0	1	0	3	4
Total	52	43	19	86	200

TABLE 7

	Patients with Malignancy	*Irradiated in Utero*	*%*
McMAHON (6) U.S.A.	556	85	15.3%
STEWART (13) G.B.	1299	222	13.7%
PATERSON (16) U.S.A.	144	41	28.4%

results of pelvimetry were compared with management and outcome. He concluded that in only five per cent of that group of patients was the x-ray pelvimetry necessary. He further suggested the discontinuance of x-ray pelvimetry.

There is experimental and statistical evidence[1,9,11,12,13,14] which displays a potential risk inherent in fetal exposure to x-ray, with such exposure being correlated with an increased incidence of malignancy in infancy and childhood (Table 7).

Conclusion

In reviewing our findings we cannot agree with those who desire to eliminate x-ray pelvimetry. It did identify 22 patients who had dysfunctional labor associated with an inadequate or borderline pelvic capacity. We do agree, however, with those who believe x-ray pelvimetry should be reserved for those patients most likely to receive benefit. These are patients who are in active labor and have displayed dysfunctional labor.

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16. Paterson (quoted in 13).

1978 Student Research Convocation West Virginia University School Of Medicine

THE Fourteenth Annual Medical Student Research Convocation was held on March 23, 1978. The Convocation is conducted annually in honor of Dr. Edward J. Van Liere, Dean Emeritus of the West Virginia University Medical School, who served as Chairman of the Department of Physiology from 1921 to 1955 and as Dean of the School of Medicine from 1935 to 1961. Students participating in the Convocation compete for the Edward J. Van Liere Award which consists of a plaque plus $100. The Award was established in 1965 by action of the Faculty of the School of Medicine to recognize the research efforts of our medical students and to honor Doctor Van Liere. The winner of the Edward J. Van Liere Award this year was David Henderson, Medicine II. The first runner-up and winner of $50 was William Payne, Medicine IV, and the second runner-up and winner of $25 was John Muldoon, Medicine II. Publication of the abstracts in *The West Virginia Medical Journal* constitutes an important and greatly appreciated recognition of the research efforts of our medical students.

W. E. Gladfelter, Ph. d., *Chairman*
Medical Student Research Convocation Committee

The Cardiopulmonary Effects Of Alprazolam— A New Benzodiazepine Derivative

EDWYN L. BOYD
Medicine IV, Morgantown.
RICHARD B. KNAPP, M. D.
WILLIAM H. HESS, M. D.

ALPRAZOLAM is a new benzodiazepine derivative with good anxiolytic properties whose cardiopulmonary effects have not previously been studied in man. The object of this study was to determine any cardiopulmonary effects in a prospective, double-blind study in healthy, awake, fasted human volunteers.

The 18 subjects were randomly divided into three groups. Group I received alprazolam 1 mg. orally; group II received alprazolam 2 mg. orally, and group III received an identical capsule containing placebo. There was no statistically significant difference between the groups in regard to age, height, or weight.

Following control measurements of systolic and diastolic blood pressure, heart rate, respiratory rate, oral temperature, minute volume, minute volume response to 5 per cent CO_2 in 95 per cent O_2 and cardiac output as measured by the IFM Minnesota Impedance Cardiograph, each subject was medicated with a capsule containing one of the three doses. All measurements were then repeated at 45 minutes, 90 minutes, 180 minutes, and 8 hours postmedication. At 90 minutes each subject was also shown a memory card to test post-study recall.

Ingestion of either 1 or 2 mg. of alprazolam resulted in no statistically significant decrease from control in systolic blood pressure, CO_2 response, cardiac output, or stroke volume as shown by analysis of variance. Six subjects, all receiving alprazolam, failed to recall the memory card when questioned 24 hours post-study.

In healthy, awake, volunteers, oral alprazolam in the 1 and 2 mg. dosage forms does not depress either cardiac output, stroke volume, systemic blood pressure, or the ventilatory response to inhaled CO_2, and also possesses antirecall properties.

Feasibility Of Direct Coronary Blood Flow Measurements In Intact Human Subjects

DAVID HENDERSON
Medicine II, Summersville.
ALLEN F. BOWYER, M. D.

No method is currently available to measure blood flow in individual coronary arteries in intact man. The purpose of this research was to develop and test the feasibility of such a method based on tracing the flow path and velocity of microbubbles injected into coronary arteries. The study was conducted in two steps.

First, a model system was constructed in which the coronary arteries were simulated by silastic tubing of assorted sizes. Renografin-76 and saline were infused as the flowing contrast agent. The apparatus was filmed in the field of an x-ray image amplifier by a cineangiographic camera. Flow of the contrast material was measured with a volumetric flow meter and bubble velocity was computed from the angiographs. The correlation coefficient between bubble velocity and measured flow was 0.995 ($P < .001$), ($n=50$).

Cardiac catheterization sometimes results in the unintentional injection of microbubbles into the coronary circulation with no apparent morbidity or mortality. In part two of the study, coronary angiograms from 50 patients in which microbubbles were inadvertently injected into the coronary circulation were analyzed. A mathematical representation of the particular coronary artery was derived from two orthogonal x-ray images. Computer graphic methods were used to represent the artery as a curve in three-dimensional space. The location of the microbubble was then traced from point to point by the three-dimensional spatial representation of the coronary artery. True velocity was computed from frame-by-frame location of bubble position. Bubble flow was, as expected, highest in diastole, lowest in systole, highest in larger vessels, lowest in smaller vessels.

In conclusion, bubble-flow measurement may provide an accurate assessment of individual coronary arterial flow valuable to both the cardiologist and cardiovascular surgeon contemplating coronary revascularization on a patient.

Magnetometry/Pathology Correlative Study Of Coal Workers' Pneumoconiosis

MICHAEL W. JOPLING
Medicine II, Morgantown
FRANCIS H. Y. GREEN, M. D.

The ferromagnetic mineral component of respirable coal dust has been detected and quantitated non-invasively in the lungs of coal workers. Preliminary clinical studies have shown that even small amounts of ferromagnetic contaminants (FC) are measurable in normal controls, with higher levels in active and retired miners. Further investigation was required to determine if these high dust loads are predictive for coal workers' pneumoconiosis (CWP) and thus hasten its application to clinical situations. Currently, radiology is the primary means of evaluating CWP, but suffers from a lack of sensitivity due to similar densities of coal dust and normal tissue, potential ionizing radiation hazards, and a poor correlation between radiologic abnormality in CWP with physiologic and pathologic changes.

Magnetometry, the mapping of the magnetic field produced by the inspired FC, overcomes these disadvantages of radiology and yields information on dust retention and clearance mechanisms making possible the ability to identify

individuals susceptible to CWP. Thus, it could become an important tool for preventive medicine. To validate the use of magnetometry for assessing CWP it was necessary to correlate magnetometric measurements with the amount of coal dust in the lungs, histopathology and radiology.

Initially, six right lungs from miners and nonminers were obtained at autopsy, matched for age and sex; full clinical and occupational histories were obtained. The lungs were inflated, freeze-dried (nothing added—only water removed), and radiographed. Magnetometric assessment was via a SQUID magnetometer (superconducting quantum interference device). After magnetization in a uniform field (0.0425 tesla), magnetometric mappings were made over the anterior, bilateral and posterior anatomic planes. The lungs were then remagnetized with the field direction reversed and the measurements repeated. This corrects for effects due to endogenous ion currents and the diamagnetic susceptibility of human tissue to the earth's magnetic field and allows calculation of the component due only to FC.

The lyophylized lungs were then sliced into 300 μm sections and high contrast photographs made of the cut surface. Then, using a computerized image analysis system, the coordinates and size of all pigmented areas from selected slices were obtained. Assuming a constant proportion of FC within the pigment it was possible to predict mathematically the magnetometric readings. Randomly-selected blocks of lung tissue were also removed and routine histopathology performed to assess extent and severity of pathologic change. Provisional results correlating the magnetometric readings with the pathology suggest that magnetometry can accurately measure the amount of coal dust in a miner's lung.

An Evaluation Of Potentially Preventable Perinatal Mortality In West Virginia For 1975

ROGER LEWIS
Medicine II, Morgantown.
R. J. C. PEARSON, M. B., M. P. H.
WILLIAM A. NEAL, M. D.
DAVID J. S. HUNTER, M. B., Ch. B.
BETTE G. HINTON, M. D., M. P. H.
ROSALYN C. PARKINSON, M. A.

The primary aim of the project was to discriminate between socio-economic factors, which are slow to change, and health care delivery factors, as the more important reasons for the high infant and fetal mortality rates in West Virginia. The method used was to review all matched infant birth-death certificates and fetal death certificates in 1975 to look for health care delivery factors.

The infant deaths were then placed into three categories: those weighing less than 1500 grams, those which were probably nonpreventable, and those which were potentially preventable. The medical judgments were made by an expert panel of physicians who determined that 109 of the 505 infant deaths were potentially preventable. The 109 potentially preventable deaths may have been prevented if they had received better health care. Because of the lack of pertinent information, no assessment could be made on the role of socio-economic factors.

There were 334 fetal deaths, of which the 149 weighing more than 2000 grams were reviewed. The fetal death certificates in general were poorly filled out, but 23 of these large fetal deaths occurred during labor and probably could have been prevented. One third, or 50, of these large fetal deaths did not indicate the time of death, while 25 per cent of the certificates recorded no cause of death.

West Virginia ranked 49th of all states with an infant mortality of 18.4 in 1975. Had the 109 infant deaths been prevented it would have dropped to 14.2, well below the national average of 16.1. If these deaths could be prevented in the future, West Virginia's infant mortality would improve dramatically, even without a change in socio-economic factors.

Tumor-Associated Antigens In Cervical Carcinoma

JOHN D. MULDOON
Medicine II, Salem.
ROBERT W. VELTRI, Ph. D.
PETER E. MAXIM, Ph. D.
JOSH C. TUNCA, M. D.

THIS project was undertaken to investigate the presence of tumor-associated antigens (TAA) in extracts of cervical carcinoma, to compare these TAA to other TAA and tumor-related proteins, and to test the possibility of using TAA in the diagnosis of cervical carcinoma.

The antigen preparations were soluble proteins extracted from cervical carcinomas. Immune sera to these antigens were prepared by immunizing New Zealand White rabbits. The antisera were adsorbed with extracts of normal cervical tissue, pooled human serum, and extracts of pooled normal human tissues.

The presence of two possible TAA was confirmed using Ouchterlony double immunodiffusion. One antigen was associated with the soluble extract while the other was detectable in the sonicate extract of tumor cell membranes. They were found not to be CEA, AFP, Beta-2 microglobulin or any normal human serum protein. Also, these antigens did not cross react with extracts of carcinoma of the breast or colon.

The specificity of these TAA was further examined by using the Indirect Immunofluorescence Test on cell smears of normal cervical tissue and tissue from cervical carcinoma. The preliminary results showed a positive fluorescence with the tumor tissue, but little or no fluorescence was seen with the control slides. Although the data are preliminary, the Indirect Immunofluorescence Test may represent a valuable tool in the cytologic diagnosis of cervical carcinoma.

Prenatal CNS Toxicity Of A Polychlorinated Biphenyl

WILLIAM N. PAYNE
Medicine IV, Huntington.
S. M. CHOW, M. D., Ph. D.

POLYHALOGENATED biphenyl compounds have become recognized in the United States as important pollutants, especially after the accidental contamination by polybrominated biphenyls of cattle feed in Michigan in 1973. The transplacental toxicity to the fetus of the related compound tetrachlorinated biphenyl (TCBP) has been investigated in laboratory mice where it causes a variety of anomalies in various organ systems. TCBP (98 to 99 per cent pure; 32mg/kg/day) was given orally to pregnant mice (CD-1 strain) on days 10 through 16 of gestation. Many of the pups (about 55 per cent of the newborns in 60 litters) manifested hyperkinesia, spinning, and jerking movements of the neck by 14 days of age.

The purpose of this investigation is to study the effects of TCBP on the nervous system, especially the peculiar spinning behavior manifested lifelong by many of these mice. Similar spinning behavior can be produced by placing lesions in various areas of animal brains which generally appear to be involved in the anatomical pathways between the substantia nigra and the corpus striatum; these animals are then given various drugs (such as amphetamine, apomorphine, and L-DOPA) to elicit or modify the spinning behavior. TCBP-spinning mice were dosed with the above compounds and also with such dopamine antagonists as haloperidol and chlorpromazine to test if these compounds alter the spinning behavior.

The results indicate that the dopaminergic system is involved in the spinning of TCBP-treated mice, and a hypothesis to explain this involvement is presented. Histopathology and transmission electron microscopy are also performed to evaluate morphological changes in the nigro-striatal system and compare them to other lesions affecting the anterior horn neurons of the spinal cord. The pathomechanism of a defect in synaptogenesis which is induced by TCBP *in utero* is proposed to account for these anatomical findings and behavioral abnormalities.

A message from . . .

The President

SOME EARLY GOALS

It is one thing to set goals—and another to accomplish them. Generally, carrying out any difficult and worthwhile objective requires a reasonable period of time.

There are some matters that appear to need the particular attention of the Medical Association. One is the complicated regulatory patchwork with which we all must live each day. There must be some way, legislative or otherwise, through which the regulatory process could be streamlined. We need to give serious thought to searching for, and hopefully finding, such a path with the help of those who can be of the most assistance in such an endeavor.

Then there is the need for more emphasis on health education and nutrition in our primary and secondary schools. Not more classes in the old physical education mold, but some good, solid instruction by qualified teachers that would develop in our youngsters a basic understanding of these topics so that they can enjoy healthier lives. We hope to talk to appropriate leaders in our educational system about this goal.

In August, this Association's House of Delegates adopted a resolution calling upon the leadership to review with the West Virginia Society of Osteopathic Medicine the feasibility of a single licensing examination for physicians practicing in the state. Such a dialogue will be instituted as soon as possible.

There are other objectives of perhaps equal or more importance to us as we constantly strive to do a better job for our patients and the public, but here are three that offer substantial food for thought. We'll appreciate your reaction to them.

Robert D. Hess M.D.

Robert D. Hess, M. D., *President*

The West Virginia Medical Journal

Editorials

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author shall be held entirely responsible.

CARBON MONOXIDE POISONING

Much has been written about carbon monoxide poisoning. During the past two decades several editorials have appeared on this subject in *The Journal.* It is still pertinent to call attention to the grave danger of carbon monoxide poisoning now that cold weather will soon be here.

Because of the energy crisis people have been urged to insulate their homes carefully in order to save on their fuel bill. While this is undoubtedly sound advice, unfortunately, the more or less thorough insulation has increased greatly the danger of carbon monoxide poisoning in the home. It obviously follows that the better the room has been insulated the greater the danger. It is known that even .1 of one per cent of carbon monoxide in the air of an enclosed room may build up a dangerous percentage of carbon monoxide hemoglobin in the body.

The diagnosis of carbon monoxide poisoning is not always easy to make, but nausea, headache, dizziness and vomiting should alert the physician to the possibility of carbon monoxide poisoning. It should be noted that the skin does not always show a dusky red color in this condition. Recently, Kelly and Sophocieus[1] have called attention to the fact that retinal hemorrhages are often found in carbon monoxide poisoning. The hemorrhages occur in the nerve fiber layer of the retina. These authors point out the finding of retinal hemorrhages aid in establishing the diagnosis of carbon monoxide poisoning. This is an important observation.

One of the grave dangers of carbon monoxide poisoning, and one that is not appreciated by the layman, are the possible aftereffects. In severe cases of poisoning the cells of the cerebral cortex may be irreparably injured, and nothing can be done, of course, to restore their normal function. It is even possible, as Drinker[2] has pointed out, that the patient may be practically decerebrated.

Obviously, a patient who has suffered carbon monoxide poisoning should be removed immediately from his previous environment and be allowed to breathe normal air. The carbon monoxide is gradually eliminated from the body. If the patient is allowed to breathe pure oxygen, carbon monoxide elimination will be hastened, and if pure oxygen can be administered under pressure (hyperbaric oxygenation) elimination will be further increased.

Finally, the most important thing of all is to prevent carbon monoxide poisoning. Gas stoves in the home should be carefully checked so that no leaks occur; care should be taken to see that chimneys are not obstructed, and people should be constantly warned of the imminent danger of starting an automobile in an enclosed garage. In sum, deaths due to carbon monoxide poisoning can practically be eliminated if necessary precautions are strictly observed.

1. Kelly JC, Sophocieus GJ: *JAMA* 229:1515 (April), 1978.
2. Drinker CK: *Carbon Monoxide Asphyxia,* New York, Oxford University Press, p 133, 1933.

EAT TO LIVE

Across the United States one notes in novelty shops and boutiques a poster of a corpulent porker with the admonition, "Eat to live, don't live to eat," printed prominently along its hog back. This inspires comment, but no action. A combination of self-delusion, increasing affluence and general availability of good things to eat has made Americans the most overweight and underexercised society in the world.

For the first 50 million years on earth man obtained his food by foraging and hunting like other animals. He later learned to grow fruits and vegetables and raise livestock to eat. Only in the last several generations have we gone to the market place and filled a grocery cart with a multitude of edibles including many processed or "junk" foods. The evening meal may last from

six o'clock news through the late, late show. It seems our nutritional way of life has taken a 180° turn for the worse.

Man has evolved from a hungry hunter to a satiated slob. This has contributed to the current epidemic of premature atherosclerosis. Coronary heart disease in the past has affected middle-aged and elderly people, but necropsy studies show that it now occurs in adolescents and young adults. Myocardial infarction is common in men in their 30's and 40's and not uncommon in menstruating females. Routine serum fat studies frequently show hypercholesterolemia and hypertriglyceridemia. This in turn may relate to excess weight and high fat and carbohydrate intake. It seems that if we are to turn this national catastrophe around we will have to accept a new philosophy, one that is now foreign to our nature:

1. To be healthy we must be hungry.
2. To make a conscious commitment to eat as little as necessary to maintain ideal body weight.
3. To adhere to a high protein, low carbohydrate, low fat diet as a "way of life."
4. To avoid fad diets, crash programs and diet pills.
5. To learn that eating is a habit and once established a reasonable diet is as satisfying as gluttony.
6. Eat to live, don't live to eat.

MORE FEVER

I understand that Mr. Califano has now proposed that Blue Cross and Blue Shield Plans which have governing boards or physician-reimbursement committees comprised mostly of members who have "a strong financial stake in the health care industry" be prohibited from settling Medicare or Medicaid claims.

Viewed cursorily, the proposition seems merely run-of-the-mouth stuff from the Secretary. Hardly worth a raised eyebrow. However, closer examination is warranted and will reward the thoughtful members of his audience with a broader understanding of the Washington sickness, Potomac fever.

Obviously, the proposer of such prohibitions believes that "people out there" can't be trusted to disburse money. In this case, specifically, the untrustworthy people are those who provide health care to the citizens of this country and the money they are disbursing is designated to pay for health care previously rendered in good faith by the same untrustworthy people.

Another symptom of the fever is Mr. Califano's tycoon-like attitude toward the money he has been hired to disburse. Of course, it is mailed to Washington by "the people out there"—including the untrustworthy ones—and, after it gets there it becomes government property—seemingly the personal fortunes of whatever bureaucrats happen to be hired by the politicans in power. The bureaucrats then emerge as mail-order millionaires, delivering what they select regardless of what was ordered. In spite of the considerable shrinkage which affects the mailed-in money (the politicians help themselves to what they think they are worth and pay the bureaucrats to collect and then disburse it), there are still enough fortunes in the countless federal budgets to create a countless number of government-issue tycoons.

Note, also, that the Secretary's proposition does not concern itself with qualifications but with disqualifications. There is no appeal for understanding or objectivity or integrity or compassion or even literacy. There is only the pronouncement of categorical disqualification, issued with a threat which, if executed, would disrupt the already muddled and cumbersome health-administration industry for years and add more millions to the nonproductive costs of the program.

In pursuit of his convictions, Mr. Califano says he will ask the governors of states which have laws requiring provider majorities on some Blue Cross/Blue Shield governing boards to seek modifications of such laws. In his efforts to persuade the governors, it is presumed he will convince them, through the presentation of facts, figures and statistics, that people who provide health care in their states cannot be trusted to determine who should be paid or what care should be paid for. Also, it is presumed, he will define for the several governors just which of their residents do not have a "strong financial stake in the health care industry." And, it should be added, the way the Washington sickness is afflicting it.

Demagoguery and paternalism are epidemic along the banks of the Potomac, frequently obscure but pathognomonic symptoms of the fever which is characteristic of the region.—*Journal of the Oklahoma State Medical Association.*

GENERAL NEWS

Doctor Hess Assumes Presidency Of Medical Association

Dr. Robert D. Hess of Clarksburg, a family physician who is now Director of Medical Education at United Hospital Center, Inc., there, has assumed duties as the new President of the West Virginia State Medical Association.

Doctor Hess was installed as President by Dr. Tom E. Nesbitt of Nashville, Tennessee, President of the American Medical Association, at the concluding session of the House of Delegates during the 111th Annual Meeting Saturday, August 26, at the Greenbrier in White Sulphur Springs.

Doctor Nesbitt was the principal speaker during the Saturday afternoon House session.

The convention began with a meeting of the Council on Wednesday, August 23. The official registration totalled 450 and included 320 physicians.

Dr. Joseph A. Smith of Dunbar, the retiring President, presided at Wednesday and Saturday sessions. He automatically became Chairman of the Council for the new Association year, succeeding Dr. John J. Mahood of Bluefield.

Other New Officers

Elevated to President Elect from Vice President was Dr. Stephen D. Ward of Wheeling, who will be installed as President during the 1979 Annual Meeting, also scheduled at the Greenbrier next August 22-25. Doctor Ward is a psychiatrist.

Dr. L. Walter Fix of Martinsburg was elected Vice President and Dr. Kenneth G. MacDonald, Sr., of Charleston was re-elected to his 14th one-year term as Treasurer. Doctor Fix is a pathologist and Doctor MacDonald is a surgeon.

Dr. Richard E. Flood of Weirton was re-elected to a two-year term as a Delegate to the AMA, with Dr. Harry S. Weeks, Jr., of Wheeling re-elected as Alternate Delegate.

Five new Council members were elected, with four other physicians re-elected to two-year terms.

The five new Councilors are Drs. William L. Mossburg of Fairmont, Leo H. T. Bernstein of Martinsburg, Vernon E. Duckwall of Elkins, Harry Lee Shannon of Parkersburg, and Carl R. Adkins of Fayetteville.

Re-elected were Drs. Winfield C. John of Huntington, Carl J. Roncaglione of Charleston and Arthur E. Levy of Williamson. Dr. Dewey F. Bensenhaver of Petersburg, who was appointed to Council last year for one year, was elected to the second year of the two-year term.

Holdover Councilors whose terms will expire in 1979 are Drs. David H. Williams, Weirton; Ralph W. Ryan, Morgantown; M. V. Kalaycioglu, Shinnston; Roger Paul Bennett, Webster Springs; John B. Markey, Charleston; David F. Bell, Jr., Bluefield, and Doctor Bensenhaver.

Under the terms of the Association's Constitution, Doctor Mahood, the Council Chairman last year, becomes Councilor-At-Large for 1978-79; and Dr. Jack Leckie of Huntington, the Associa-

Stephen D. Ward, M. D.
President Elect

tion Past President three years removed, will serve as Junior Councilor-At-Large during this period.

Amendments and Resolutions

During the two sessions of the House of Delegates, two sets of proposed amendments were introduced (see separate story about, and complete texts of, proposed amendments elsewhere in this issue of *The Journal*), and seven resolutions were adopted (complete texts of resolutions also appear elsewhere in this issue of *The Journal*).

The resolutions will result in such things as:

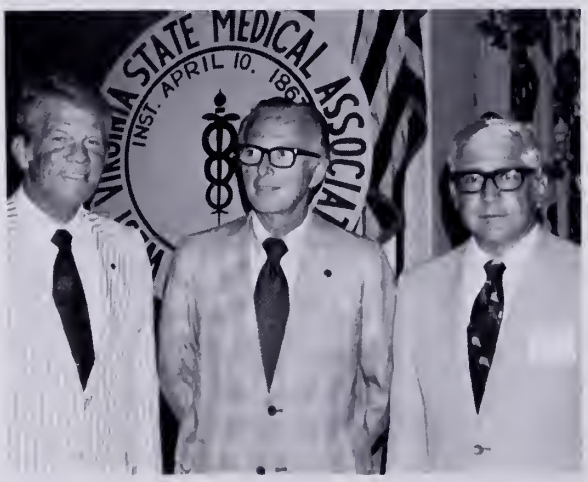
—A further increase, from $1.250 to $1,500, in the annual value of medical scholarships awarded by the Medical Association, effective with those entering first-year medical school classes in 1979-80.

—Continued work toward more extensive physical rehabilitation services in West Virginia.

—Further development of a continuing medical education program for physicians licensed in the state.

The President

A native of Bridgeport, Doctor Hess was graduated from Potomac State College and West Virginia University; and received his M. D. degree from the Medical College of Virginia in Richmond in 1958. He served an internship and residency at Charleston Memorial Hospital in 1958-60 before entering private practice in Bridgeport in July, 1960.



Dr. Tom E. Nesbitt (center) of Nashville, Tennessee, President of the American Medical Association, addressed the second and final session of the House of Delegates on Saturday, August 26, at the conclusion of the 111th Annual Meeting of the West Virginia State Medical Association, August 23-26, at the Greenbrier in White Sulphur Springs. Shown with Doctor Nesbitt are Drs. Robert D. Hess (left) of Clarksburg, who was installed as the Association's President for 1978-79, and John J. Mahood of Bluefield, Immediate Past Chairman of the Association's Council and now Councilor-At-Large.

Doctor Hess has served as Treasurer, Secretary, President-Elect and President (in 1973) of the Harrison County Medical Society; and was a member of the Association's governing Council from 1973 to 1976, when he was elected Vice President. He has served as President-Elect for the past year.

Doctor Hess was a member of the Association's Committee on Medical Scholarships from 1967 through 1976; has been active on the Committee on Medical Education and Hospitals, and has served as Chairman of the West Virginia University Liaison Committee while also holding a number of other committee assignments. He holds a faculty position at the WVU School of Medicine as Clinical Professor in the Department of Family Practice.

He also currently is Chairman of the West Virginia Joint Council on Teaching Hospitals; a member of the West Virginia Medical Institute, Inc., Board; Treasurer of the West Virginia Chapter, American Academy of Family Physicians; a charter Fellow of the AAFP, and a charter Diplomate of the American Board of Family Practice.

A member of the American Medical and Southern Medical Associations, Doctor Hess has served as President of the medical staff and as a board member at Clarksburg hospitals; and has been active in a variety of local voluntary health, medical service, civic and United Methodist Church organizations.

Doctor Hess left private practice in September, 1976, to become Director of Medical Education at United Hospital Center, Inc., a position he had held on a part-time basis beginning in 1974. In 1966-72, he was Harrison County's Coroner.

Doctor Hess is married to the former Alice Jo Morrison of Weston, and they are the parents of five children: John Robert, Mary Katheryn, Monica Ann, Michael Raymond and Joseph Francis.

The President Elect

Doctor Ward is Editor of *The West Virginia Medical Journal* and Chairman of the Association's Publication Committee. A member of the Association's Council for four years, beginning in 1969, he currently is a member of the American Medical Association's Council on Legislation.

He received his M. D. degree in 1964 from the University of Pittsburgh School of Medicine. He served an internship at Mercy Hospital in Pittsburgh, and a residency at the Western Psychiatric Institute and Clinic of the University of

Pittsburgh School of Medicine from 1955 to 1958.

Doctor Ward, who entered practice in Wheeling in 1962, is a Past President of the Ohio County Medical Society. He serves on the Association's Legislative, Mental Health, Public Service and Program committees, and the Federal Medical Activities Sub-Committee of the Medical Economics Committee.

The Vice President

Doctor Fix becomes Vice President after completing two terms on the Association's Council, beginning in 1974.

A native of Buffalo, New York, he was graduated from the State University of New York at Buffalo, receiving his M. D. degree in 1943 from that institution's School of Medicine. He interned at the U. S. Naval Hospital in Brooklyn, New York, and completed a residency in pathology in 1950.

Doctor Fix also has completed graduate work in forensic pathology, ophthalmologic pathology, and tropical medicine.

He is a member of the Association's Cancer, Insurance and Legislative committees, and the Ad Hoc Committee on Professional Liability.

Doctor Fix became a member of the state Association in 1956.

First House Session

Doctor Smith presented to Dr. John E. Jones, Dean of the West Virginia University School of Medicine, a check for $15,695.28; and to Dr. Robert W. Coon, Dean of the Marshall University School of Medicine, a check for $4,062.59, during the first session of the House of Dele-

New Society In Jefferson Receives State Charter

The West Virginia State Medical Association has a new component society, its 28th.

In action during the Association's 111th Annual Meeting in August at the Greenbrier, the House of Delegates approved issuance of a charter to the new Jefferson County Medical Society.

Physicians in Jefferson have belonged to the Eastern Panhandle Medical Society, which supported establishment of the new component. The Jefferson Society's initial officers are Dr. Earl Douglas Allera of Charles Town, President; Dr. L. Mildred Williams, Charles Town, Vice President; and Dr. S. K. G. Menon, Ranson, Secretary-Treasurer.

New officers of the West Virginia State Medical Association were elected during the 111th Annual Meeting August 23-26 at the Greenbrier in White Sulphur Springs. Newly elected and other officers shown above are, seated, from left, Drs. L. Walter Fix, Martinsburg, Vice President; Joseph A. Smith, Dunbar, Immediate Past President and now Chairman of the Association's Council; Robert D. Hess, Clarksburg, President; Stephen D. Ward, Wheeling, President Elect, and Winfield C. John, Huntington, re-elected to Council. Standing, from left, are Drs. Vernon E. Duckwall, Elkins, elected to Council; Arthur E. Levy, Williamson, and Carl J. Roncaglione, Charleston, both re-elected to Council; Kenneth G. MacDonald, Sr., Charleston, Treasurer, and Leo H. T. Bernstein, newly elected to Council. Not shown are Drs. William L. Mossburg, Fairmont; Harry Lee Shannon, Parkersburg, and Carl R. Adkins, Fayetteville, all elected to Council, and Dr. Dewey F. Bensenhaver, Petersburg, appointed to Council last year for one year and elected to the second year of the two-year term.

Shown in the center photo (left) is James A. Reynolds of Oradell, New Jersey, Executive Editor of Medical Economics. Mr. Reynolds spoke on "The Outlook for Medicine in 1984 and Beyond" during opening exercises preceding the first general session on Thursday morning, August 24, at the State Medical Association's 111th Annual Meeting at the Greenbrier in White Sulphur Springs. With him are Dr. Maurice A. Mufson (center) of Huntington, who was moderator for the first general session, and Dr. David B. Gray of Charleston, the 1978 Program Committee Chairman. In the left photo, during the initial session of the Association's House of Delegates on Wednesday, August 23, Dr. Joseph A. Smith (right), then Association President, presents to Dr. Robert W. Coon, Dean of the Marshall University School of Medicine, a check for $4,062.59. In the right photo, Doctor Smith presents to Dr. John E. Jones, Dean of the West Virginia University School of Medicine, a check for $15,695.28. The checks represented an annual contribution by West Virginia physicians and the Auxiliary to the medical schools through the Education and Research Foundation of the American Medical Association.

gates on Wednesday afternoon. The checks represented an annual contribution by West Virginia physicians and the Auxiliary to the medical schools through the Education and Research Foundation of the AMA.

Opening Session

Mr. James A. Reynolds of Oradell, New Jersey, addressed physicians during opening exercises preceding the first general scientific session on Thursday morning. Mr. Reynolds is Executive Editor of Medical Economics.

Program Committee for 1979 Holds Initial Meeting

Planning for the scientific program to be offered as a part of the State Medical Association's 112th Annual Meeting at the Greenbrier in White Sulphur Springs next August 22-25 already is under way.

The 1979 Program Committee, with Dr. Arthur A. Abplanalp of Charleston as Chairman, held its initial meeting at the Greenbrier on Friday, August 25, during the Association's 111th Annual Convention.

Others appointed by Dr. Robert D. Hess of Clarksburg, the Association's President, to serve on the Committee are Drs. Marshall J. Carper of Charleston, Cordell A. de la Pena of Clarksburg, George J. Hill II of Huntington, Robert H. Waldman of Morgantown and Stephen D. Ward of Wheeling, the Association's President Elect.

The Huntington Clinical Foundation has contributed $5,000 to the Marshall University Foundation, Inc., earmarked for cancer research to be carried out by the MU School of Medicine. Clinical Foundation head L. F. Norton, center, presented the check to Dr. Bernard Queen, left, Executive Director of the Marshall Foundation. Shown with them is Dr. George J. Hill, Professor and Chairman of the medical school's Surgery Department, who will direct the research into the effects of combination treatment by surgery, radiation therapy, chemotherapy and immunotherapy on adult cancer patients.

Standing and Special Committees Appointed By Doctor Hess

Here is a list of the standing, special and ad hoc committees which have been named by Dr. Robert D. Hess of Clarksburg, President of the West Virginia State Medical Association, to function during his one-year term of office.

Aging

Lee B. Todd, Quinwood, Chairman; Myer Bogarad, Weirton; Arthur L. Calhoun, West Union; Richard Hamilton, St. Marys; Sam Milchin; Bluefield, Virginia; Ralph H. Nestmann and Pat A. Tuckwiller, Charleston.

Cancer

David B. Gray, Charleston, Chairman; Alvin L. Watne, Morgantown, Vice Chairman; John J. Battaglino, Jr., Wheeling; Walter B. Bice, Jr., and F. Lloyd Blair, Parkersburg; William B. Blake, Jr., Huntington; Bobby Lee Caldwell, Charleston; James P. Carey, Huntington; Cordell A. de la Pena, Clarksburg; L. Walter Fix, Martinsburg; S. William Goff, Parkersburg; Arthur E. Levy, Williamson; Catalino B. Mendoza, Jr., Clarksburg; Hu C. Myers, Philippi; Robert W. Neilson, Bluefield; Morris H. O'Dell, Charleston; Jess S. Renedo, Wheeling and John W. Trenton, Kingwood.

Constitution and By-Laws

John J. Mahood, Bluefield, Chairman; George R. Callender, Jr., Charleston; Richard E. Flood, Weirton; Carl B. Hall, Charleston; J. C. Huffman, Buckhannon; Richard V. Lynch, Jr., Morgantown; Joseph B. Reed, Buckhannon; Joseph T. Skaggs, Charleston; Harry S. Weeks, Jr., Wheeling and J. Hugh Wiley, Morgantown.

Insurance

Lyle D. Vincent, Parkersburg, Chairman; James L. Bryant, Clarksburg; John T. Chambers, Charleston; David V. Cole, Point Pleasant; R. U. Drinkard, Wheeling; L. Walter Fix, Martinsburg; F. Perry Greene, Jr., Parkersburg; H. Summers Harrison, Morgantown; James A. Heckman and C. A. Hoffman, Huntington; Edward Jackson, St. Albans; Kenneth G. MacDonald, Sr., and A. Thomas McCoy, Charleston; Buford W. McNeer, Hinton; C. Vincent Townsend, Martinsburg and John F. I. Zeedick, Charleston.

Sub-Committee on Investments and Trust

C. A. Hoffman, Chairman; John T. Chambers (1979); A. Thomas McCoy (1980); Kenneth G. MacDonald, Sr. (1981) and James L. Bryant (1982).

Ad Hoc Committee on Professional Liability

Jack Leckie, Huntington, Chairman; John T. Chambers, Charleston; L. Walter Fix, Martinsburg; William E. Gilmore, Parkersburg; Kenneth G. MacDonald, Sr., Charleston and Worthy W. McKinney, Beckley.

Interprofessional Relations

William E. Gilmore, Parkersburg, Chairman.

Sub-Committees

Medico-Legal: Charles W. Merritt, Beckley, Chairman; John C. Bryce, Parkersburg; John F. Otto, Huntington and Paul H. Revercomb, Charleston.

Medicine and Religion: Joe N. Jarrett, Oak Hill, Chairman; Marshall J. Carper, South Charleston and William L. Neal, Huntington.

Medicine and Pharmacy: L. Dale Simmons, Clarksburg, Chairman; Donald E. Cunningham, St. Albans and John L. Fullmer, Morgantown.

Medical-Dental Liaison: John A. B. Holt, Charleston, Chairman; George L. Armbrecht, Wheeling; Alberto G. Capinpin, Charleston and Gene Lee Hackleman, Huntington.

Nurses Liaison: Richard E. Flood, Weirton, Chairman; Billie M. Atkinson, Parkersburg; Jean P. Cavender and Peter A. Haley, Charleston; Asel P. Hatfield, Harrisville and L. Dale Simmons, Clarksburg.

Legislative

Frank J. Holroyd, Princeton, Chairman; W. Alva Deardorff, Charleston, Vice Chairman; W. P. Bittinger, Oak Hill; A. Paul Brooks, North Parkersburg; George R. Callender, Jr., Charleston; William H. Carter, Williamson; John T. Chambers, Charleston; George A. Curry, Morgantown; Del Roy R. Davis, Kingwood; Vernon E. Duckwall, Elkins; Roy A. Edwards, Jr., and A. C. Esposito, Huntington; L. Walter Fix, Martinsburg; Richard E. Flood, Weirton; George Gevas and William E. Gilmore, Parkersburg; Paul E. Gordon, Clarksburg; Louis W. Groves, Jr., Richwood; N. B. Groves, Martinsburg; Carl B. Hall, John M. Hartman and John A. B. Holt, Charleston; J. C. Huffman, Buckhannon; M. V. Kalaycioglu, Shinnston; Jack Leckie, Huntington; Milton J. Lilly, Jr., and A. Thomas McCoy, Charleston; Paul L. McCuskey, Parkersburg; Worthy W. McKinney, Beckley; Harvey A. Martin, White Sulphur Springs; Charles W. Merritt, Beckley; Louis C. Palmer, Bridgeport; Joseph D. Romino, Fairmont; Carl J. Roncaglione, South Charleston; Joseph T. Skaggs, James T. Smith and Pat A. Tuckwiller, Charleston; A. J. Villani, Welch; Lyle D. Vincent, Parkersburg; Stephen

D. Ward, Wheeling; Henry F. Warden, Jr., Bluefield; Harry S. Weeks, Jr., and Robert R. Weiler, Wheeling; J. Hugh Wiley, Morgantown and Moseley H. Winkler, Charleston.

Maternal and Perinatal Fetal Welfare

David J. S. Hunter, Morgantown, Chairman; Samuel J. Bracken, Wheeling; Larry D. Curnutte, Charleston; Robert D. Crooks, Parkersburg; Frederick H. Dobbs, Charleston; T. Keith Edwards, Bluefield; W. Gene Klingberg, Morgantown; George S. Kosar, Weirton; A. Robert Marks, Clarksburg; William A. Neal, Morgantown; Thomas G. Potterfield, Charleston; Robert P. Pulliam, Beckley; Narinder N. Sehgal, George A. Shawkey and Robert E. Stone, Charleston and Charles A. White, Morgantown.

Sub-Committee on Perinatal Fetal Welfare

W. Gene Klingberg, Morgantown, Chairman; Robert D. Crooks, Parkersburg; A. Robert Marks, Clarksburg; Thomas G. Potterfield and George A. Shawkey, Charleston.

Medical Aspects of Sports

K. Douglas Bowers, Jr., Morgantown, Chairman; Dewey Bensenhaver, Petersburg; A. Paul Brooks, North Parkersburg; Colin M. Craythorne, Huntington; Clemente Diaz, Richwood; Thomas O. Dotson, White Sulphur Springs; James S. Kessel, Ripley; Walter E. Klingensmith, Beckley; Charles A. Lefebure, Clarksburg; Tony C. Majestro, Charleston; George Naymick, Weirton; Carl J. Roncaglione, South Charleston; George W. Rose, Clarksburg; James K. Sexton, Charleston; Clifford Sperow, Martinsburg; Robert R. Weiler, Wheeling and Robert S. Wilson, Clarksburg.

Medical Economics

Robert L. Ghiz, Charleston, Chairman; and Harry S. Weeks, Jr., Wheeling, Vice Chairman.

Sub-Committees

Federal Medical Activities: W. Alva Deardorff, Charleston, Chairman; Everett S. Fogle, Martinsburg; Grover C. Hedrick, Jr., Beckley; David J. S. Hunter, Morgantown; J. L. Mangus, Charelston; Richard John Pearson, Morgantown; James F. Slaughter, Dunbar; James T. Spencer, Charleston and Stephen D. Ward, Wheeling.

State Workmen's Compensation: Carl J. Roncaglione, South Charleston, Chairman; Marshall J. Carper, South Charleston; James V. Gainer, Jr., Clarksburg; Sherman E. Hatfield, Charleston; Ralph J. Holloway, South Charleston; Lawrance S. Miller, Morgantown; Milton E. Nugent, Wheeling; Roy R. Raub, Princeton and Ralph S. Smith, Jr., Charleston.

Blue Cross-Blue Shield Third Party: J. D. H. Wilson, Clarksburg, Chairman; Robert W. Bess, Jr., Piedmont; Donald R. Chadwick, Beckley; Albert C. Esposito, Huntington; Ernest G. Guy, Philippi; Milton J. Lilly, Jr., Charleston; John F. Otto, Huntington; Richard C. Rashid, South Charleston; Richard O. Rogers, Jr., Bluefield and Edward C. Voss, Wheeling.

Public Welfare-Joint Conference Committee: John B. Markey, Charleston, Chairman; Charles E. Andrews, Morgantown; Clemente Diaz, Richwood; Harold P. Dinsmore, Roneeverte: Richard E. Flood, Weirton; Lewis N. Fox, MacArthur; William H. Harriman, Jr., Terra Alta; Kenneth B. Lauren, West Union; Seigle W. Parks, Charleston and Hiram Sizemore, Jr., Shepherdstown.

United Mine Workers Welfare and Retirement Fund: Thomas P. Long, Man, Chairman; Arthur A. Carr, Welch; Ray A. Harron, Bridgeport; John M. Hartman, Charleston; John William Kennard, Wheeling; Elbert Leon Linger and Lawrence B. Thrush, Clarksburg and Lee B. Todd, Quinwood.

Vocational Rehabilitation: Robert L. Ghiz, Charleston, Chairman; George R. Callender, Jr., and Carrel M. Caudill, Charleston; Creel S. Cornwell, Jr., Clarksburg; Charles M. Davis, Jr., and W. Gene Klingberg, Morgantown; Joseph T. Mallamo, Fairmont; Ralph S. Smith, Jr., Charleston; William H. Wanger, R. James Yates and Nicholas D. Zambos, Beckley.

Medical Education and Hospitals

R. James Yates, Beckley, Chairman; Charles E. Andrews, Morgantown; Leo H. T. Bernstein, Martinsburg; Thomas J. Beynon, Weirton; William H. Carter, Charleston; T. H. Chang, Clarksburg; John S. Cook, Welch; Robert W. Coon, Huntington; Creel S. Cornwell, Jr., Clarksburg; Jack E. Cox, Farmington; C. Richard Daniel, Beckley; Del Roy R. Davis, Kingwood; Thomas O. Dotson, White Sulphur Springs; William J. Echols, Huntington; T. Keith Edwards, Bluefield; Albert C. Esposito, Huntington; Alfred D. Ghaphery, Wheeling; Guy F. Hollifield, Beckley; George M. Kellas, Wheeling; George S. Kosar, Weirton; Mary Lou L. Lewis and William O. McMillan, Jr., Charleston; David Z. Morgan, Morgantown; Maurice A. Mufson and Dennis S. O'Connor, Huntington; R. Wade Ortel, Wheeling; John F. Otto, Huntington; Herbert H. Pomeranee, Charleston; L. Dale Simmons, Clarksburg; Robert L. Smith, Morgantown; Michael M. Stump V, Elkins; Charles W. Thacker, Par-

kersburg; John W. Traubert, Morgantown; C. Carl Tully, South Charleston; Charles E. Turner, Huntington and J. Hugh Wiley, Morgantown.

Medical Emergencies and Civil Defense

Jack Leckie, Huntington, Chairman; Adla Adi, Charleston; John V. Brannon, Bridgeport; Frederick M. Cooley, Charleston; William D. Crigger, South Charleston; E. Jane Freeman, Bridgeport; Henry R. Glass, Jr., Charleston; James C. Hazlett, Wheeling; Jules F. Langlet, Charles Town; Walter H. Moran, Jr., Morgantown and William E. Walker, Huntington.

Medical Scholarships

John Mark Moore, Wheeling, Chairman; R. L. Chamberlain, Buckhannon; Marshall J. Carper, South Charleston; John M. Daniel, Beckley; William E. Gilmore, Parkersburg; Thomas J. Holbrook, Huntington; James T. Hughes, Ripley; Kenneth G. MacDonald, Sr., Charleston and Clark K. Sleeth, Morgantown.

Mental Health

Roy A. Edwards, Jr., Huntington, Chairman; Mildred Mitchell-Bateman, Huntington; Donald C. Carter, Morgantown; Randall Connolly, Vienna; Ray S. Greco, Weirton; David P. Hill, Wheeling; Florence K. Hoback, Huntington; James Paul Markham, Clarksburg; Larry C. Smith, Huntington; Ralph S. Smith, Jr., Charleston; Demosthenes Soulis, Bluefield; Stephen D. Ward, Wheeling and Charles C. Weise, Charleston.

Military Medical Affairs

Bert Bradford, Jr., Charleston, Chairman; David R. Hess, Bridgeport; Logan W. Hovis, Vienna and James K. Sexton, Charleston.

Program

Arthur A. Abplanalp, Charleston, Chairman; Marshall J. Carper, South Charleston; Cordell de la Pena, Clarksburg; George J. Hill II, Huntington; Robert H. Waldman, Morgantown and Stephen D. Ward, Wheeling.

Public Service

C. R. Davisson, Weston, Chairman; Leonard M. Eckmann, South Charleston; Albert C. Esposito, Huntington; G. Thomas Evans, Fairmont; Louis W. Groves, Jr., Richwood; N. B. Groves, Martinsburg; E. Lee Jones, Wheeling; C. A. Logue, Morgantown; L. J. Pace, Princeton; Jack J. Stark, Belpre, Ohio; Stephen D. Ward, Wheeling and A. J. Weaver, Clarksburg.

Resolutions

Richard E. Flood, Weirton, Chairman; George R. Callender, Jr., Charleston; William E. Gilmore, Parkersburg; Winfield C. John, Huntington; John J. Mahood, Bluefield; Worthy W. McKinney, Beckley; Joseph A. Smith, Dunbar and Harry S. Weeks, Jr., Wheeling.

Rural Health

N. Allen Dyer, Princeton, Chairman; Harold D. Almond, Buckhannon; J. C. Arnett, Rowlesburg; Ralph H. Boone, Sistersville; B. S. Brake,

In the left photo, Dr. Gwendolyn R. Hogan, of Jackson, Mississippi, is shown with Dr. Harold R. Berger of Elizabeth, New Jersey. Doctor Hogan was one of the speakers for the first general session, a "Symposium on New Methods for Treatment of Common Disorders," on Thursday morning, August 24, during the State Medical Association's Annual Meeting in August at the Greenbrier. In the center photo, two additional speakers for the first general session, Drs. John W. Eckstein (left) of Iowa City, Iowa, and Ruy V. Lourenco of Chicago (right) are shown with Dr. Joseph T. Skaggs of Charleston during the President's Reception for Honor Guests on Wednesday evening. In the right photo, Dr. Mary Lou L. Lewis of Charleston, the remaining speaker for the first general session, is shown during a coffee break with Dr. John D. Harrah of Huntington.

Clarksburg; Robert W. Coplin, Elizabeth; Earl L. Fisher, Gassaway; O. M. Harper, Clendenin; Joe N. Jarrett, Oak Hill; Charles T. Lively, Weston; George Naymick, Weirton and Charles J. Sites, Franklin.

School Health

Thomas L. Thomas, Wheeling, Chairman; R. J. Bailey, Parkersburg; J. M. Brand, Chester; Hugh M. Brown, Clarksburg; Thomas G. Folsom, Barboursville; Peter A. Haley, Charleston; Grover C. Hedrick, Jr., Beckley; Mary Jordan, Fairmont; Edward Shupala, Parkersburg and Eli J. Weller, Weirton.

Tuberculosis

Harry K. Tweel, Huntington, Chairman; Charles E. Andrews, Morgantown; John A. Bellotte, Bridgeport; Robert M. Biddle, Parkersburg; J. M. Brand, Chester; William L. Cooke and Dominic J. Gaziano, Charleston; N. LeRoy Lapp, Morgantown; Ralph H. Nestmann, Charleston; Robert J. Reed III, Wheeling; Donald P. Stacks, Huntington; M. A. Viggiano, New Martinsville; James H. Walker, Charleston; Herbert E. Warden, Morgantown and David H. Williams, Weirton.

Venereal Disease

N. H. Dyer, Charleston, Chairman; Donald E. Farmer, Charleston; L. H. Mills, Clarksburg; Frank M. Peck, Huntington; David S. Pugh, Chester; Page H. Seekford, Charleston; Thomas L. Thomas, Wheeling; Lyle D. Vincent, Parkersburg; K. William Waterson, Wheeling and Isaiah A. Wiles, Morgantown.

AMA-ERF

J. Keith Pickens, Clarksburg, Chairman; Irwin M. Bogarad, Weirton; Russell R. Brandon, Chesapeake, Ohio; Harry F. Cooper, Beckley; John E. Echols, Richwood; John H. Gile, Parkersburg; Joseph Gilman, Clarksburg; Robert W. Howes, Jr., Parkersburg; Joe N. Jarett, Oak Hill; M. Bruce Martin, Huntington; William T. Lawson, Fairmont; Burford W. McNeer, Hinton; David Z. Morgan, Morgantown; Donald R. Roberts, Elkins; George A. Shawkey, Charleston; John W. Trenton, Kingwood; Lysle T. Veach, Petersburg and E. Andrew Zepp, Martinsburg.

WVU Medical Liaison

James L. Bryant, Clarksburg, Chairman; Robert A. Crawford, Jr., Charleston; Kenneth J. Allen, Glen Dale; William E. Barnes, Parkersburg; Dewey F. Bensenhaver, Petersburg; R. S. Birckhead, Gauley Bridge; W. T. Booher, Jr., Wellsburg; K. Douglas Bowers, Jr., Morgantown; A. Kyle Bush, Philippi; Terrell Coffield, New Martinsville; C. Richard Daniel, Beckley; Del Roy R. Davis, Kingwood; G. Thomas Evans, Fairmont; Donald E. Farmer, Charleston; Richard E. Flood, Weirton; John M. Grubb, Point Pleasant; Carl B. Hall, Charleston; J. C. Huffman, Buckhannon; Joe N. Jarrett, Oak Hill; Kenneth G. MacDonald, Sr., Charleston; Ross E. Newman, Mullens; Robert R. Pittman, Martinsburg; Russell A. Salton, Williamson; Robert G. Shirey, Lewisburg; L. Dale Simmons, Clarksburg; John

Shown in the left photo are Dr. Irvin M. Sopher (left) of Charleston and Dr. Edward E. Mason of Iowa City, Iowa, two of the speakers for the second general session on Friday, August 25, during the State Medical Association's recent Annual Meeting at the Greenbrier. In the center photo, Dr. David J. S. Hunter (right) of Morgantown, the remaining speaker for the second general session, listens as he is asked a question following the session. Shown with him is Dr. Ruth C. Harris of Huntington. In the right photo, Karen A. Zupko of Chicago, Director, Department of Practice Management, American Medical Association, is shown explaining sample brochures following her presentation which constituted the third general session on Saturday morning, August 26. Shown examining the printed material are, from left, Drs. Richard C. Rashid, South Charleston; M. Bruce Martin, Huntington, and Harvey H. Ammerman, President of the Medical Society of District of Columbia.

W. Traubert, Morgantown; A. J. Villani, Welch; Herbert E. Warden and J. Hugh Wiley, Morgantown.

Marshall Medical Liaison

Winfield C. John, Huntington, Chairman; Carl R. Adkins, Fayetteville; David F. Bell, Jr., Bluefield; John S. Cook, Welch; John M. Daniel, Beckley; Albert C. Esposito, Huntington; Andrew H. Henderson, Turkey Creek, Kentucky; C. A. Hoffman, Huntington; I. M. Kruger, Logan; Muthusami Kuppusami, Welch; Jack Leckie, Huntington; Arthur E. Levy, Williamson; Thomas P. Long, Man; Houston B. Moore, Lewisburg; Joseph T. Skaggs, Charleston; Richard L. Slack, Point Pleasant; Charles E. Turner, Huntington; Robert Bruce Walker, Hamlin and R. James Yates, Beckley.

Doctors W. W. Huffman, Hiles Elected Honorary Members

The State Medical Association's Council elected Drs. W. W. Huffman of Gassaway, a member of the Central West Virginia Medical Society, and Charles H. Hiles of Hilton Head, South Carolina, a member of the Ohio County Medical Society, to honorary membership in the state organization at its August 23 meeting in White Sulphur Springs.

Both physicians earlier had been accorded honorary membership in their component societies, and they, along with others elected by Council during the past year, received further honorary membership approval by the Association's House of Delegates later on August 23.

In other action at its meeting preceding the Association's 111th Annual Meeting at the Greenbrier, Council:

—Expressed appreciation for service provided by Drs. Lyle D. Vincent of Parkersburg and Walter E. Klingensmith of Beckley, who were not eligible for re-election to Council this year. Drs. Wallace B. Murphy of Grafton and Joseph T. Mallamo of Fairmont later chose not to seek re-election to second two-year terms. Dr. Murphy died in a Grafton hospital September 10.

—Reviewed proposed Constitution and By-laws amendments and resolutions to be introduced at the first House of Delegates session later in the day; and approved the introduction by Council of a resolution calling for continued development of a continuing medical education program for physicians licensed in the state.

—Heard presentations by State Insurance Commissioner Richard Shaw; State Welfare Commissioner Leon Ginsberg; and Mr. Hugh F. Hughes of Columbus, Ohio, Manager of Medicare Field Operations for Nationwide Insurance in West Virginia.

—Accepted an invitation from the Greenbrier to return August 22-25, 1979, for the Association's 112th Annual Meeting.

Golf, Tennis, Skeet Winners Decided At Convention

Dr. Marcel G. Lambrechts of Charleston, shooting a 79, won the Medical Golf Tournament during the State Medical Association's Annual Meeting at the Greenbrier in August. Mrs. William E. Gilmore of Parkersburg repeated as the winner of the Auxiliary links competition.

Drs. Maurice A. Mufson of Huntington and Rabindran Israel of Charleston won the Association's tennis tournament, limited to doubles teams. Drs. Thomas J. Janicki of Charleston and William J. Echols of Huntington finished second, with the team of Drs. Harold Selinger of Charleston and L. E. Chapman, Jr., of Seabrook, Texas, third.

Mrs. Prospero B. Gogo and Mrs. Joseph A. Maiolo, both of Beckley, were the doubles winners in the Auxiliary tennis tournament.

Doctor Israel won the Medical Association skeet tournament, with Dr. David R. Hess of Bridgeport the runner-up.

EENT Academy Sets Spring Meeting

The National Spring Meeting of the West Virginia Academy of Ophthalmology and Otolaryngology will be held April 22-25, 1979, at the Greenbrier in White Sulphur Springs.

Speaking for the ophthalmology meeting will be Drs. D. Jackson Coleman, Charles D. Kelman and Richard C. Troutman, all of New York City; Kenneth J. Hoffer, Santa Monica, California, and Robert Machemer, Miami, Florida.

The otolaryngology speakers will be Drs. Thomas C. Calcaterra, Los Angeles; Michael E. Glasscock, Nashville, Tennessee; Charles J. Krause, Iowa City, Iowa, and M. Stuart Strong, Boston.

Hotel accommodations should be made directly with the Greenbrier. Checks for the registration fee of $225 should be made payable to The West Virginia Academy of Ophthalmology and Otolaryngology and addressed to: J. Elliott Blaydes, M. D., The Blaydes Clinic, Corner of Frederick and Woodland Avenue, Bluefield 24701.

Review A Book

The following books have been received by the Headquarters Office of the State Medical Association. Medical readers interested in reviewing any of these volumes should address their requests to Editor, *The West Virginia Medical Journal*, Post Office Box 1031, Charleston 25324. We shall be happy to send the books to you, and you may keep them for your personal libraries after submitting to *The Journal* a review for publication.

Current Obstetric & Gynecologic Diagnosis and Treatment, 2nd Edition, by Ralph C. Benson, M.D. 976 pages. Price $18. Lange Medical Publications, Los Altos, California 94022. 1978.

Review of Medical Pharmacology, 6th Edition, by Frederick H. Meyers, M. D.; Ernest Jawetz, M. D., Ph. D.; and Alan Goldfien, M. D. 762 pages. Price $14.50. Lange Medical Publications, Los Altos, California 94022. 1978.

Everything You Always Wanted to Know About Nutrition, by David Reuben, M. D. 287 pages. Price $9.95. Simon and Schuster, New York, New York 10020. 1978.

For the first time in many years, all members of the State Medical Association's Publication Committee this year were present for the meeting of the Committee held annually during the Association's Annual Meeting. Shown at the meeting of the Committee held during the 111th Annual Meeting of the Association in August at the Greenbrier are, seated, from left, Drs. Stephen D. Ward of Wheeling, Editor of The West Virginia Medical Journal and Chairman of the Committee; E. J. Van Liere, Morgantown (Dean Emeritus of the West Virginia University School of Medicine), and John M. Hartman, Charleston, Associate Editors of The Journal. Standing, from left, are Drs. Thomas J. Holbrook, Huntington; L. Walter Fix, Martinsburg; Joe N. Jarrett, Oak Hill, and Vernon E. Duckwall, Elkins, all Associate Editors.

Continuing Education Activities

Here are the continuing medical education activities listed primarily by the West Virginia University School of Medicine for part of 1978, as compiled by Dr. Robert L. Smith, Assistant Dean for Continuing Education. The schedule is presented as a convenience for physicians in planning their continuing education program. (Other national, state and district medical meetings are listed in the *Medical Meetings* Department of The Journal.)

The program is tentative and subject to change. It should be noted that weekly conferences also are held on the Charleston and Wheeling campuses as well as in Morgantown. Further information about these may be obtained from: Division of Continuing Education, WVU Medical Center, 3110 MacCorkle Avenue, S.E., Charleston 25304; Office of Continuing Medical Education, WVU Medical Center, Morgantown 26506; or, Office of Continuing Medical Education, Wheeling Division, WVU School of Medicine, Ohio Valley Medical Center, 2000 Eoff Street, Wheeling 26003.

Oct. 5	Morgantown	Annual Pediatric Day
Oct. 6, 7	Morgantown	Critical Care Symposium
Oct. 14	Wheeling	Medicine Day Seminar
Oct. 20, 21	Charleston	Medical and Social Problems of the Elderly
Oct. 27, 28	Morgantown	American College of Surgeons
Nov. 3, 4	Morgantown	Neuroscience Teaching Day
Nov. 3, 4	Morgantown	Cardiology Teaching Days
Nov. 9	Wheeling	Family Practice Seminar
Nov. 17, 18	Morgantown	Emergency Medicine Seminar
Dec. 6	Morgantown	Infant Nutrition
To Be Announced	Charleston	Third Annual Allergy Workshop
To Be Announced	Charleston	Psychiatric Seminar

Doctors Kluge, Stevenson Conference Speakers

Two additional speakers for the 12th Mid-Winter Clinical Conference to be held in Charleston next January 26-28 were announced by the Program Committee.

Ronica M. Kluge, M. D.

Mabel M. Stevenson, M. D.

They are Dr. Ronica M. Kluge of Morgantown, who will speak during the Saturday (January 27) morning session on "Current Practices in Immunization," and Dr. Mabel M. Stevenson of Huntington, a speaker for the Sunday morning session on "Current Concepts in Hematology."

Doctor Kluge, Associate Professor and Chairman of the Division of Infectious Diseases at the West Virginia University Medical Center, will speak on "Influenza Virus Vaccines."

Doctor Stevenson is Medical Director of the Tri-State Red Cross Blood Center in Huntington. Her talk will be entitled, "Current Use of Blood Products."

The conference, to be held at the Holiday Inn Charleston House, will begin Friday afternoon, January 26, and continue through noon on Sunday. Scientific sessions for physicians will be held Friday afternoon, Saturday morning and afternoon, and Sunday morning.

The annual continuing education event is sponsored by the State Medical Association and the West Virginia and Marshall University Schools of Medicine.

There will be a session on coronary artery disease Saturday afternoon and, as announced previously, a session on physical fitness, obesity and diet therapy Friday afternoon. The latter session will be developed as a public program Friday evening.

The conference schedule also will include a Friday evening physicians' session, held concurrently with the public session, and a dinner program Saturday evening.

The Friday evening physicians' session will consist of a presentation on physicians' Individual Practice Associations (IPAs).

In the left photo, AMA President Tom E. Nesbitt, M. D. (left), administers the oath of office to Dr. Robert D. Hess of Clarksburg, who was installed as President of the State Medical Association during the second and final session of the Association's House of Delegates on Saturday, August 26, the concluding day of the Association's 111th Annual Meeting at the Greenbrier. Shown in the center photo are, from left, Dr. Jack Leckie of Huntington, Dr. Joseph T. Skaggs of Charleston and D. John Pecorino, LL. B., of Hartford, Connecticut. Mr. Pecorino, Manager, Commercial Insurance Department, Aetna Life & Casualty, addressed physicians on "State and National Trends in Professional Liability Insurance" following the first House session on Wednesday. In the right photo, Dr. Charles F. Scholhamer (left), also of Hartford, is shown with Dr. C. A. Hoffman of Huntington, a Past President of both the State Medical Association and the AMA. Doctor Scholhamer, Associate Medical Director for Aetna, also spoke following the first House session on "Malignancy in Malpractice Claims." Aetna is the Association's carrier for professional liability insurance.

Native of Florida

Doctor Kluge, a native of St. Petersburg, Florida, went to WVU in November, 1976, from the University of Florida College of Medicine in Gainesville where she was Chief of the Division of Infectious Diseases.

She received her M. D. degree in 1967 from the University of Florida, completing an internship, residencies and other graduate work at the University of Maryland Hospital in Baltimore and the Veterans Administration Hospital there.

Doctor Kluge held teaching appointments at the University of Maryland from 1970 until joining the staff at the University of Florida in 1974.

She was certified by the American Board of Internal Medicine in 1972 and, also by that board, in infectious diseases in 1974. She is a Fellow of the American College of Physicians and a member of the American Federation of Clinical Research, American Society for Microbiology, Infectious Diseases Society of America, and American Association for the Advancement of Science.

Doctor Kluge is the author or co-author of some 26 scientific papers and abstracts.

Formerly On WVU Staff

A native of Ireland, Doctor Stevenson went to Huntington in 1976 after holding various teaching appointments at WVU since 1963. At the time she left WVU she was Professor of Pathology and Director of the Blood Bank.

Doctor Stevenson is certified by the American Board of Clinical Pathology and the American Board of Blood Banking and Immunohematology. She received her medical education at Queen's University of Belfast Faculty of Medicine in Ireland, and completed graduate work at Royal Victoria Hospital in Belfast.

She was a research fellow in blood coagulation in Melbourne, Australia, in 1957-58, and was a staff physician and Director of Laboratories at Rochester (Minnesota) State Hospital from 1958 to 1961.

Doctor Stevenson is a member of the American Association of Blood Banks, the American Society of Hematology, American Society of Clinical Pathology, Society of Academic Clinical Pathologists and Scientists, the Council on Thrombosis, American Heart Association, and the American Society for Histocompatibility Testing.

She was Chairman of the Blood Program, Morgantown Chapter of the American Red Cross, from 1968 to 1973.

Doctor Stevenson is the author or co-author of some 14 scientific articles.

Her husband is Dr. Robert J. Marshall of Huntington.

The speakers for the Friday afternoon session, as announced, will be Dr. Fred L. Allman, Jr., The Sports Medicine Clinic, Atlanta, on "Overuse Syndromes in the Recreational Athlete;" Dr. Ruth C. Harris, Professor and Chairman of Pediatrics, MU School of Medicine, "Our Overgrown Children," and Dr. Frederick J. Stare, Professor of Nutrition (Chairman of the Department of Nutrition, 1942-76), Harvard University School of Public Health, "Management of Cholesterol and Triglycerides."

Program Accreditation

The program meets the criteria for credit in Category 1 of the Physician's Recognition Award of the American Medical Association, and is expected to carry prescribed credit by the American Academy of Family Physicians.

Serving on the Program Committee are Drs. Ralph H. Nestmann and Joseph T. Skaggs, both of Charleston, Co-Chairmen, and Drs. William O. McMillan, Jr., Charleston; Maurice A. Mufson, Huntington; Robert L. Smith, Morgantown, and C. Carl Tully, South Charleston.

Additional details, including other conference speakers, will be provided in later issues of *The Journal* as the program is completed.

CAMC Pediatrics Guest Lecture Series

The Department of Pediatrics, Charleston Area Medical Center, has announced its 1978-79 Guest Lecture Series. The Charleston Division, West Virginia University Medical Center, is the co-sponsor.

The dates, speakers and their topics are:

"Preoperative, Operative and Postoperative Pediatric Fluids"—Frederic A. Berry, Jr., M. D., Department of Anesthesiology, University of Virginia Hospital, Charlottesville, November 2; "Radiation Therapy in Pediatric Cooperative Groups"—Melvin Tefft, M. D., Professor of Radiation Medicine, Brown University School of Medicine, Providence, Rhode Island, January 4, 1979;

"Some Aspects of Genetic Counseling"—Lytt Gardner, M. D., Professor of Pediatrics, State University of New York Upstate Medical Center, Syracuse, March 1, 1979, and "Newer Aspects of Childhood Tuberculosis"—Saul Blatman,

M. D., Chairman Emeritus, Department of Pediatrics, Dartmouth University Medical School, Hanover, New Hampshire, May 24, 1979.

A guest lecture on "Infant Nutrition—A Foundation for Lasting Health?" was held on September 7. Speaking was Avroy Fanaroff, M. D., Associate Professor of Pediatrics, Case Western Reserve University School of Medicine.

SMA, MAG To Hold Joint November Meeting

Dr. Jay P. Sanford, Dean of the new Medical School of the Uniformed Services of the Health Sciences, Bethesda, Maryland, and Dr. Arthur H. Keeney, Dean of the University of Louisville Medical School, will head a list of speakers addressing the first joint Scientific Assembly of the Southern Medical Association and the Medical Association of Georgia, November 11-14, at the Georgia World Congress Center in Atlanta.

Over 3,000 physicians from 16 southern states and the District of Columbia are expected to attend.

New concepts and treatments in 23 medical specialties will be covered in the four-day meeting, to include 17 postgraduate courses.

The event marks the 72nd annual scientific assembly of the SMA.

Dr. Andrew F. Giesen, Jr., of Ft. Walton Beach, Florida, SMA President, will be honored at a luncheon Monday, November 13, with columnist Art Buchwald as guest speaker. Dr. Thomas B. Dameron, Jr., of Raleigh, North Carolina, will be installed as 1978-79 President during the Atlanta meeting.

Dr. C. H. William Ruhe, Senior Vice President for Scientific Activities of the American Medical Association, will give the 1978 Abner W. Calhoun Lecture at the MAG luncheon Saturday, November 11. His topic is "1984: Nightmare or Utopia for Medical Education?"

Topics for discussion will range from "The Role of Cingulotomy in the Treatment of Psychiatric Illness" by Dr. H. Thomas Ballantine, Jr., senior neurosurgeon of Massachusetts General Hospital, to "Behavioral Approaches to the Headache" by Dr. Redford B. Williams, Jr., of the psychology and medical faculty of Duke University.

The assembly is approved for Category I credit toward the AMA Physicians' Recognition Award and offers 77 prescribed and 168 elective hours of credit to members of the American Academy of Family Physicians.

Mrs. Robert J. Reed Installed As Auxiliary President

Mrs. Robert J. Reed III of Triadelphia assumed the Presidency of the Auxiliary to the West Virginia State Medical Association at the group's 54th Annual Meeting at the Greenbrier in White Sulphur Springs, August 23-26.

Mrs. Robert J. Reed III

Mrs. Reed was installed by Mrs. Manuel A. Bergnes of Norristown, Pennsylvania, President of the Auxiliary to the American Medical Association, who was an honor guest.

Also attending was Mrs. M. Bruce Martin of Huntington, President of the Auxiliary to the Southern Medical Association.

Mrs. Reed, whose husband is a cardiovascular and thoracic surgeon in Wheeling, succeeded Mrs. Joseph T. Mallamo of Fairmont. The Auxiliary elected Mrs. D. Sheffer Clark of Huntington as President Elect and the following additional officers:

Mrs. Richard S. Kerr of Morgantown, Vice President; Mrs. Gary G. Gilbert of Huntington, Recording Secretary; Mrs. Robert O. Strauch of Wheeling, Corresponding Secretary; Mrs. J. Dennis Kugel of Charleston, Treasurer, and Mrs. Harry S. Weeks, Jr., of Wheeling, Parliamentarian;

Mrs. George Naymick, Newell, Northern Regional Director; Mrs. E. G. Friera, Romney, Eastern Regional Director; Mrs. E. M. Spencer, Bluefield, Southern Regional Director; Mrs. Charles E. Turner, Huntington, Western Regional Director, and Mrs. Logan W. Hovis, Vienna, Central Regional Director.

Committee Appointments

Mrs. Reed also announced these appointments of committee chairmen:

Mrs. Charles E. Andrews, Morgantown, AMA Education and Research Foundation; Mrs. M. Bruce Martin, Huntington, Bylaws and Handbook; Mrs. John J. Schaefer, Charleston, News Bulletin Editor; Mrs. Alfredo C. Velasquez, Charleston, News Bulletin Circulation;

Mrs. J. L. Mangus, Charleston, Finance; Mrs. Harry E. Coffman, Keyser; Mrs. Harvey Reisenweber, Martinsburg, and Mrs. E. L. Gage, Bluefield, Health Careers Scholarship Loan Fund; Mrs. Phillip W. Hall, Clarksburg, Necrology;

Mrs. Miroslav Kovacevich, Charleston, Press and Publicity; Mrs. Herbert E. Warden, Morgantown, Caduceans Liaison; Mrs. Harry S. Weeks, Jr., Wheeling, WESPAC; Mrs. Joe N. Jarrett, Oak Hill, and Mrs. Joseph T. Mallamo, Fairmont, Long-Range Planning; Mrs. Albert C. Esposito, Huntington, Southern Medical Association Councilor; Mrs. A. G. Capinpin, Charleston, SMA Vice Councilor;

Mrs. Joseph A. Smith, Dunbar, Legislation; Mrs. Robert O. Strauch, Wheeling, Archives and History; Mrs. D. Sheffer Clark, Huntington, Membership; Mrs. Richard S. Kerr, Morgantown, Members-At-Large, and Health Program Development (Project Bank).

New officers of the Auxiliary to the West Virginia State Medical Association were elected during the group's 54th Annual Meeting at the Greenbrier in White Sulphur Springs August 23-26. In the first row, from left, are Mrs. Robert J. Reed III, Triadelphia, President; Mrs. D. Sheffer Clark, Huntington, President Elect; Mrs. Richard S. Kerr, Morgantown, Vice President, and Mrs. J. Dennis Kugel, Charleston, Treasurer. In the second row, from left, are Mrs. Gary G. Gilbert, Huntington, Recording Secretary; Mrs. Charles E. Turner, Huntington, Western Regional Director; Mrs. E. G. Friera, Romney, Eastern Regional Director; Mrs. George Naymick, Newell, Northern Regional Director, and Mrs. Logan W. Hovis, Vienna, Central Regional Director. Not shown is Mrs. E. M. Spencer, Bluefield, Southern Regional Director.

Native of Ohio

Mrs. Reed (Sharon), daughter of Mr. and Mrs. William Denger of Mt. Pleasant, Ohio, was born and reared in the Buckeye State. Her early education was in the Mt. Pleasant public school system. Having chosen nursing as a career, she attended the Ohio Valley Hospital School of Nursing in Steubenville, Ohio. She was graduated with the highest academic achievement in her class. Upon receiving licensure, she was employed as a staff nurse at the Martins Ferry Hospital. It was there that she met, and later married, Doctor Reed. Intensive care nursing then became a challenge to Sharon, and transferring to the Ohio Valley Medical Center in Wheeling, she pursued this field until the birth of their son, Robbie, in 1972.

Mrs. Reed was quite active in the Auxiliary to the Ohio County Medical Society and was soon serving as its President. Her interest in auxiliary work grew and she dedicated herself to serving on the state as well as county level. State positions previously held were Northern Regional Director, Corresponding Secretary, Vice President and President Elect.

In addition to her auxiliary work she is active in other community programs; a member of both local hospital auxiliaries; a certified Red Cross Nurse working with the bloodmobile; an active member of the Junior League of Wheeling, Inc.; a member of the Vance Memorial Presbyterian Church, presently serving on the Stewardship Commission, and a Board Member of the United Presbyterian Women. She formerly was a Sunday School teacher and member of the Christian Education Commission.

Residing in Clinton Hills near Oglebay Park, she has been the Secretary-Treasurer of the Clinton Hills Improvement Association and a member of the Four Seasons Garden Club.

Sharon has three stepdaughters: Mrs. Randall C. Zeller (Valerie) of Los Angeles, who graduated from UCLA in 1977 and who will soon present the Reeds their first grandchild; Janis English Reed, a senior at Wellesley College who hopes to pursue a career in medicine, and Vanessa Benton Reed, a junior at Stanford University, who is still unsure of her career plans.

She makes time for fun with friends and family. Her hobbies include parlor games, tennis, golf, sewing, gardening, and working crossword puzzles.

Constitution, By-Laws Changes Introduced Into House

Two sets of proposed amendments to the State Medical Association's Constitution and By-Laws were introduced into the House of Delegates during the Association's 111th Annual Meeting at the Greenbrier in August. They will be subject to amendment and further action leading to approval or disapproval at the first House session, next August 22, during the 112th Annual Meeting.

One group of amendments, carrying out in large measure an earlier mandate of the House, would set up a new membership classification in the Association for medical students; provide for representation in the House for Resident and Medical Student Sections; and establish, in the By-Laws, guidelines under which specialty societies and sections established by the House should be organized for educational and other activity.

The other amendments up for a vote next year would provide for increased representation on the Medical Association's Council as an Association District reaches certain levels of membership. As introduced, a District (the Association has 14 embracing all sections of the state) would be entitled to a second Councilor when membership in the Association reaches 200; and an additional Councilor for each 100 members in excess of 200.

The effect of this package, if in effect now, would increase the District members currently standing at 15 (because District XI including Kanawha, Putnam, Boone and Clay Counties already has two Councilors) to 19. District XI would get a third Councilor with a membership well over 300, with Districts I (Hancock, Brooke, Ohio and Marshall), III (Monongalia and Preston) and X (Cabell, Mason, Wayne and Lincoln) each gaining a second Councilor.

To meet requirements for circulation of the proposed amendments among the membership, the complete proposals follow—with new language shown in italics and material to be deleted enclosed in parenthesis.

PROPOSED AMENDMENTS TO THE CONSTITUTION

(To Be Acted Upon Finally At the First Session of the House of Delegates During the 1979 Annual Meeting)

Article IV.—Composition

Sec. 1. This Association shall consist of active, retired, honorary and *student members.*

Sec. 2. Members. Membership in the Association shall be limited to doctors of medicine licensed to practice in West Virginia who are members of a component medical society of the West Virginia State Medical Association; *and students enrolled in accredited schools of medicine in West Virginia granting Doctor of Medicine degrees.*

Sec. 5. Student members shall be those persons enrolled in accredited schools of medicine in West Virginia granting Doctor of Medicine degrees who are qualified for membership under the By-Laws of this Association.

Article V.—House of Delegates

Sec. 1. The House of Delegates shall be the legislative and business body of the Association, and shall consist of (1) delegates elected by the *component societies; (2) delegates elected by Resident Physician and Medical Student Sections;* and (3) the President, President-Elect, Vice President and Treasurer.

Article XIV.—Amendments

Sec. 1. The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates present at any annual session, provided that such amendment shall have been presented in open meeting at the previous annual session, and that it shall have been published twice during the year in THE WEST VIRGINIA MEDICAL JOURNAL, or sent officially to each component society *and student members whose names are listed on the official roster of the Association* at least two months before the meeting at which final action is to be taken.

PROPOSED AMENDMENTS TO THE BY-LAWS

Chapter I.—Membership

Sec. 1. The name of a physician on the properly certified roster of members of a component society shall be prima facie evidence of membership in this Association, provided he has paid local and state dues and any current assessment, and provided further that he is licensed to practice medicine in West Virginia. *The membership also shall include, upon payment of state dues and any current assessment, a student enrolled and working toward a Doctor of Medicine degree, in any accredited school of medicine in West Virginia; provided, further, that the academic status of each medical student applicant for membership shall be certified by the dean of his medical school.*

Sec. 4. Each member in attendance at an annual session shall register and indicate the component society, *or Medical Student Section,* of which he is a member. When his right to membership has been verified by reference to the roster of his society *or Medical Student Section,* he shall receive a badge which shall be evidence of his right to all privileges of membership at that session. No member shall take part in any of the proceedings of an annual session until he has complied with the provisions of this Section.

Sec. 7. Dues in the amount of $150 shall be payable annually on January first, of which amount $12 shall be earmarked for the Charles Lively Memorial Scholarship Fund of the West Virginia State Medical Association; except, however, *that annual dues of members in residency programs and student members shall be $50 and $15, respectively;* and dues may be waived—upon nomination by a component society and approved by Council—for active members temporarily incapacitated for a minimum period of one year because of mental or physical illness. Any member whose dues have not been paid by April first shall be held to be delinquent and shall be automatically dropped from membership. Such member cannot be reinstated except by a majority vote of the component society, *or Medical Student Section,* of which he was a member taken prior to the end of the calendar year.

Chapter IV.—House of Delegates

Sec. 2. Each component society shall be entitled to elect and send to the House of Delegates each year one delegate who shall be the society's secretary, and one additional delegate for every twenty (20) members or fraction thereof. A corresponding number of alternates shall be elected each year by each component society. *Resident Physician and Medical Student Sections as established under provisions of Chapter IX of these By-Laws each shall be entitled to send to the House of Delegates one delegate each year chosen according to constitutions, by-laws or other organizational principles adopted by those sections and approved by the Council of the West Virginia State Medical Association. Each such section also shall be entitled to name one alternate delegate.* An alternate who is called upon to serve in place of a delegate who is not present shall be entitled to all the rights and privileges of such delegate to the House of Delegates. In case any of the regularly elected delegates or alternates be not present at an annual meeting, the members of the component societies, *or Resident Physician or Medical Student Sections,* to which they belong who may be present shall elect a delegate or delegates pro tem.

All county society delegates, except the secretary, shall be elected for two-year terms and when more than one delegate is to be elected, such delegates shall serve staggered terms so that the terms of only one-half the delegates, or major portion thereof, of each society, shall expire in any one year.

(Note: The following proposed Chapter IX is new in its entirety.)

Chapter IX.—Sections and Societies

Sec. 1. The objectives of sections and societies organized under provisions of this Constitution and By-Laws are (a) to form closer professional relationships among physicians practicing in particular specialty areas; and among medical residents and students; and (b) to foster among physician members of particular specialties, and among residents and students, educational and other activities directed toward better patient care.

Sec. 2. Membership in a section or specialty society of licensed doctors of medicine shall be predicated upon at least one of the following: (a) a major portion of a physician's professional practice in the specialty involved; or (b) the meeting of specific membership requirements which a section or society might itself establish through adoption of its own Articles of Incorporation and/or Constitution and By-Laws. In any event, each section or society shall be the final determinant of a physician's qualifications for membership.

Sec. 3. Each section or society shall elect its own officers according to procedures and/or Con-

stitution and By-Laws mechanisms it adopts. It shall advise the Executive Secretary of the West Virginia State Medical Association of the results of each election within 10 days of such an election; and shall take other steps necessary to insure that a current roster of officers is on file with the Executive Secretary.

Sec. 4. Each section or society of licensed physicians shall establish and maintain a continuing medical education program for its membership. The specific format for such a program shall be developed by each section or society in accordance with the size and geographical location of its membership; objectives of particular significance to that society; and how such programs best can be directed toward better patient care.

Sec. 5. There is hereby authorized, within the membership framework of the West Virginia State Medical Association, establishment of Resident Physician and Medical Student Sections to (a) provide for direct participation of residents and medical students in educational, business and other activities of the Association; and (b) establish effective lines of communication among young physicians, physicians-to-be and their more senior colleagues. Each such section shall develop its own constitution and by-laws or other organizational procedures, and elect its officers, under provisions of Section 3 of this Chapter; provided, however, that such a constitution, by-laws or procedural mechanism shall not be inconsistent with principles of organization of the West Virginia State Medical Association, and shall be subject to approval by the Association's Council.

As provided in Chapter IV, Section 2, of these By-Laws, the Resident Physician and Medical Student Sections each shall be entitled to elect one delegate and one alternate to the Association's House of Delegates each year. Each section shall report to the Association's Executive Secretary by May 1 of each year the names of its delegates and alternate.

Amend the Chapter headings for Chapters IX and X as follows:

CHAPTER X.—COUNTY SOCIETIES

CHAPTER XI.—MISCELLANEOUS

CHAPTER XII.—AMENDMENTS

Sec. 1. These By-Laws may be amended at any annual session by a majority vote of the House of Delegates present at that session, after the amendment has lain on the table for one day; however, if any amendments conflict with any of the provisions of the Constitution, they shall not be effective until such time as the Constitution has been amended to conform therewith.

Sec. 2. Whenever an amendment to the By-Laws has been made, it shall be the duty of the Executive Secretary to notify the secretary of each component society, *and the secretary of the Resident Physician and Medical Student Sections*, within sixty days after it has become effective. It shall be incumbent upon each component society, *and Resident Physician and Medical Student Sections*, to make such changes in *their constitutions* and by-laws, or if the society be a corporation, in its code of regulations or other fundamental body of rules for the government of the corporation, as will bring about conformity to the change in the By-Laws of the West Virginia State Medical Association. Written notice of this compliance shall be sent to the Executive Secretary within six months of such notice.

PROPOSED AMENDMENTS TO THE CONSTITUTION

(To Be Acted Upon Finally At the First Session of the House of Delegates During the 1979 Annual Meeting)

Amend Article IX, Sections 1 and 2, to read as follows:

Sec. 1. The officers of this Association shall be a President, a President Elect who shall automatically succeed to the office of President, a Vice President, an Executive Secretary, a Treasurer, (fifteen) Councilors to be elected as provided in Section 2 of this Article, and three Councilors-at-Large, who shall be the retiring president and his two immediate predecessors.

Sec. 2. The officers, except hold-over Councilors, the President and the Executive Secretary, shall be elected annually. The terms of the Councilors shall be for two years, (one from each Councilor District) with Councilors to be elected by the House of Delegates every second year as shall be provided for in the By-Laws for reapportionment of Council Districts. No Councilor shall be eligible to succeed himself after four years, as Councilor, but he may be elected after two years' absence from the Council. All these officers shall serve until their successors are elected and installed.

The term of the President, President Elect, Vice President, and Treasurer elected at the annual meeting in 1956 shall begin on January 1, 1957, and end on the last day of the meeting in that year. Thereafter, the term of the elective

officers, except members of the Council, shall be for the period of one year beginning with the installation of the President at the final session of the House of Delegates at each annual meeting.

The term of office of Councilors shall be for a period of two years beginning with the installation of the incoming President and ending on the last day of the second succeeding annual meeting, except as provided in the By-Laws pertinent to reapportionment of Councilor Districts.

PROPOSED AMENDMENT TO THE BY-LAWS

Amend Chapter VII, Section 11, by deleting material identified by enclosure within parenthesis; and substituting the new material, in italic.

Sec. 11. The tenure of all incumbent Councilors shall end with the adoption of this amendment and its conformity with the provisions in the Constitution. Thereafter, during the annual meeting at which such enabling amendments are adopted, there shall be elected one Councilor from each even-numbered Councilor District to serve for one year, and one Councilor from each odd-numbered District to serve a term of two years (except that District XI shall be entitled to two Councilors, to be elected in 1967, one for a one-year term and the second Councilor elected for a term of two years, and thereafter one shall be elected for a two-year term in each succeeding year) *with the exceptions that follow: Each Council District which has 200 members shall be entitled to two Councilors, to be elected in 1979, one for a one-year term and the second Councilor elected for a term of two years, and thereafter one shall be elected for a two-year term in each succeeding year. For each additional 100 members, a District shall be entitled to one additional Councilor, with such Councilor initially to be elected for a one-year term, and thereafter to a two year term.*

PROPOSED AMENDMENT TO THE BY-LAWS

Amend Chapter VIII, Section 5 (o) to read as follows:

Sec. 5 (o). The Committee on Nominations shall consist of (seven) district Councilors, and the Junior Councilor-at-Large, who shall serve as Chairman. The Councilors from the odd-numbered districts shall serve as the Nominating Committee in odd-numbered years, and the Councilors from even-numbered districts shall serve in even-numbered years. (The Kanawha Medical Society shall select one of its two Councilors to serve on the Committee.) *Each Councilor District which has more than one Councilor shall be represented by its senior Councilor in point of service on the Committee.* This Committee shall consider and recommend to the House of Delegates, prior to the election of officers, in its final session, its nominee for the office of President Elect, Vice President, Treasurer and the AMA Delegate and Alternate. Nothing in this Section shall serve to prevent any nominations from the floor for these respective offices.

(Note: This proposed amendment is designed to make this Section consistent with the proposed change in Chapter VII, Section 11.)

Affiliated Societies, Sections Elect New Officers

New officers elected by some of the sections and societies affiliated with the State Medical Association during the recent Annual Meeting at the Greenbrier include:

Section on Surgery—Dr. Robert J. Reed III, Wheeling, Chairman.

Section on Orthopedic Surgery—Dr. Charles M. Davis, Jr., Morgantown, President; Dr. Richard H. Sibley, Charleston, Vice President, and Dr. Arthur A. Abplanalp, Charleston, re-elected Secretary-Treasurer.

Section on Urology — Dr. James W. Lane, Charleston, President; Dr. Stanley J. Kandzari, Morgantown, Secretary-Treasurer.

Section on Dermatology — Dr. John J. Mahood, Bluefield, President; Dr. William A. Welton, Morgantown, Vice President, and Dr. Harold L. Saferstein, Wheeling, re-elected Secretary-Treasurer.

West Virginia Chapter, American College of Emergency Physicians—Dr. Jack R. Page, Charleston, President; Dr. Walter H. Moran, Jr., Morgantown, President Elect, and Dr. Thompson Pearcy, Charleston, Secretary-Treasurer.

West Virginia Radiological Society — Dr. Orlando F. Gabriele, Morgantown, re-elected President; Dr. Arthur E. Levy, Williamson, Vice President, and Dr. James T. Smith, Charleston, re-elected Secretary-Treasurer.

Plans To Cut Cost of Medicaid Eyeglasses, Hearing Aids

Plans to cut sharply the cost of eyeglasses and hearing aids paid for by the Medicaid program by up to 50 per cent through more efficient purchasing arrangements were announced recently —as part of the President's anti-inflation program—by Joseph A. Califano, Jr., Secretary of the United States Department of Health, Education, and Welfare.

Current federal Medicaid regulations allow states to pay an area's going rate for eyeglasses or hearing aids. "Many times these prices are unreasonably high," said Secretary Califano. "These high costs must and can be held down. Some states and some federal agencies have already proved that costs can be cut by as much as 50 per cent or more through changes in purchasing and payment methods."

The HEW Notice of Intent to Publish Regulations, published in the *Federal Register*, identifies specific ways savings can be realized:

- The State of Washington saved $96,000 in one year as a result of efforts to award supplier contracts on a more competitive basis. The state now purchases eyeglasses from a single manufacturer and dispenses the product through optometrists and ophthalmologists participating in the Medicaid program. This arrangement has simplified program administration and makes monitoring of quality easier.
- The U. S. Department of Defense and the Veterans Administration have also reduced eyeglass and hearing aid costs dramatically by purchasing large quantities in a group order. Through volume purchasing arrangements, the VA can now provide a veteran with a hearing aid for $200 — compared with typical retail prices of $300-$450.

States have discretion on whether to provide eyeglasses and hearing aids in their Medicaid programs. "By demonstrating that states can save money without dropping this important benefit, we hope to assure that these services are made available to as many people as possible at the lowest practical cost," Secretary Califano said.

The Health Care Financing Administration estimates that the total cost of eyeglasses and hearing aids for Medicaid patients was $100 million in fiscal year 1977 and that the federal government paid approximately 55 per cent.

State Medicaid programs are required to provide eyeglasses and hearing aids to eligible children as part of the Early and Periodic Screening Diagnosis and Treatment (EPSDT) program, but coverage is optional for the adult poor. Currently, 33 state Medicaid programs now provide eyeglasses and 27 state programs provide hearing aids to adult recipients.

MU Medical School Receives $310,500 Research Grant

A $310,500 research grant from one of the nation's largest drug companies has been received by the Marshall University School of Medicine, Dr. Robert W. Coon, Dean, announced.

The funds from Merck, Sharp & Dohme, a division of Merck & Co., Inc., were awarded to the MU medical school's Department of Medicine for a two-year efficacy study of the pharmaceutical firm's respiratory syncytial (RS) virus vaccine, Doctor Coon said.

"This is one of the most significant research grants currently held by the Marshall School of Medicine," he remarked. "We are pleased that the Merck Company has recognized our commitment to primary-care medicine in this manner."

The study may result in the elimination by immunization of one of the major childhood respiratory viruses.

"The RS virus, a distant relative of the measles and mumps virus, is the single most important virus causing upper and lower respiratory infections in infants and young children," according to Dr. Maurice A. Mufson, MU Medicine Department Chairman and Project Director.

"Illnesses attributed to the RS virus range from the common cold to more serious infections resulting in pneumonia and bronchitis," Doctor Mufson said.

"The infection is marked by sneezing, runny nose and red, watery eyes, and often the child is listless, fretful and lacks appetite, making both mother and child miserable," Doctor Mufson noted.

"Merck's vaccine, which has been used in other localities, may provide children immunity from the RS virus infections," he said.

The vaccine study will be conducted in cooperation with the MU Department of Pediatrics, headed by Dr. Ruth Harris, and Huntington area pediatricians.

Among those assisting Doctor Mufson with the project are Drs. Robert B. Belshe, Associate Professor of Medicine; Lee Van Voris, Assistant

Professor of Medicine, and Richard L. Curry, Assistant Professor of Pediatrics.

For its study of the vaccine's effects on the RS virus, the department is seeking 1,200 children between the ages of six months and three years, 11 months.

Children in the age range of six to 18 months are the most susceptible to RS virus infections. The RS virus vaccine is believed to work much the same as the measles and mumps vaccine.

"A small amount of the vaccine is introduced into the child's system, and the child's own disease-fighting cells will produce an immunity to help prevent him from getting the RS virus," explained Doctor Belshe.

"Of all the children vaccinated with this virus, the only side effects have been a few children with a slight temperature elevation and a mild redness at the site of the injection," Doctor Van Voris added.

"A few of the children participating will receive a salt water shot," Doctor Mufson noted. "This is necessary to provide our study with a control group."

Children's Learning Disabilities Conference In November

A conference on Children's Learning Disabilities will be held by the Achievement Center of Roanoke, Virginia, November 10-12 at the Greenbrier in White Sulphur Springs.

The faculty will include Ronald B. David, M. D., Associate Professor of Pediatrics and Neurology, Medical College of Virginia, Richmond; Martin Lenhardt, Ph. D., Associate Professor of Othology, Rhinology, Laryngology, and Director of Biocommunications, MCV; Gerald Wallace, Ed. D., Associate Professor of Special Education, University of Virginia, Charlottesville, and Robert H. Willoughby, Ph. D., Associate Professor of Pediatrics and Psychiatry, and Director of Learning Disabilities and Hyperactivity Clinic, University of Virginia Medical Center.

Early registration will be held from 6 to 8 P. M. on Friday, November 10, with the program on Saturday and Sunday. Discussion topics will include "Characteristics of Learning in Disabled Children," "Psychological and Perceptual Evaluation of the Learning Disabled Child," "Educational Evaluation of the Learning Disabled Child," and "Psychotherapy with the Learning Disabled Child and His Family."

Medical Meetings

Oct. 15-19—Am. Public Health Assn., Los Angeles.

Oct. 20-21—Am. Geriatrics Society, Baltimore.

Oct. 20-21—Medical & Social Problems in the Elderly (Kanawha Valley Family Practice Center), Charleston.

Oct. 21-25—Am. Society of Anes., Chicago.

Oct. 22-25—Indiana State Medical Assn., Clarksville.

Oct. 22-26—Am. Academy of Ophthalmology & Otolaryngology (Ophthal. Section), Kansas City, Mo.

Oct. 25-27—Cardiology Conference (Am. Heart Assn., University of Pittsburgh, W. Va. & Pa. Affiliates, AHA), White Sulphur Springs.

Oct. 25-29—Am. Academy of Child Psychiatry, San Diego.

Oct. 27-28—MCV/Va. Commonwealth University (50th Annual McGuire Lecture Series), Richmond.

Oct. 27-29—D. C. Medical Society, White Sulphur Springs, W. Va.

Oct. 30-Nov. 1—Pa. Med. Society, Lancaster.

Nov. 2—Dept. of Pediatrics, CAMC (Guest Lecture Series), Charleston.

Nov. 2-5—Med. Society of Virginia, Williamsburg.

Nov. 10-12—Achievement Center of Roanoke (Va.), Children's Learning Disabilities Conference, White Sulphur Springs.

Nov. 11-14—Southern Medical Assn., Atlanta.

Dec. 2-6—AMA Delegates Winter Meeting, Chicago.

Dec. 7-10—AMA Winter Scientific Session, Las Vegas.

1979

Jan. 4—Dept. of Pediatrics, CAMC (Guest Lecture Series), Charleston.

Jan. 15-18—Dept. of Anatomy, MCV (Alton D. Brashear PG Course in Head & Neck Anatomy), Richmond.

Jan. 26-28—12th Mid-Winter Clinical Conference, Charleston.

March 1—Dept. of Pediatrics, CAMC (Guest Lecture Series), Charleston.

March 7-9—Nurses Assn. of Am. College of Obstetricians & Gynecologists, Chicago.

March 30-April 1—W. Va. Chap., AAFP, Charleston.

May 24—Dept. of Pediatrics, CAMC (Guest Lecture Series), Charleston.

July 21-26—AMA Delegates Summer Meeting, Chicago.

Aug. 22-25—112th Annual Meeting, W. Va. State Medical Assn., White Sulphur Springs.

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Please register me for the Twelfth Mid-Winter Clinical Conference in Charleston, W. Va., January 26-28, 1979. My $25 registration fee is (is not) enclosed.

Name (please print) _____ *Specialty* _____

Address _____ *City* _____

WVU Medical Center
—News—

Compiled from material furnished by Mrs. Mary Ellin Wylie, Director, Medical Center News and Information Services, Morgantown, W. Va.

Departments Name New Faculty Members

Three new faculty members have been added in the Department of Pediatrics.

Barbara M. Tenney, M. D., Associate Professor, comes to WVU from New York where she was Director of Ambulatory Pediatrics at Booth Memorial Medical Center and an attending pediatrician at Bellevue Hospital Center.

Paul H. Dworkin, M. D., Assistant Professor, is a graduate of Rutgers University and the Johns Hopkins University School of Medicine. He completed his residency and a fellowship in ambulatory medicine at Childrens Hospital Medical Center of Boston.

David Z. Myerberg, M. D., Assistant Professor, is a graduate of Princeton University and the Columbia University College of Physicians and Surgeons.

Frank Zavisca, M. D., has joined the faculty of the department of anesthesiology as an Assistant Professor.

A graduate of State University of New York at Buffalo where he also received his medical degree, Doctor Zavisca received his postgraduate training at Meyer Memorial and Buffalo General hospitals and at Massachusetts General Hospital.

One professor and four assistant professors have joined the faculty of the Department of Surgery.

Cedric A. Quick, M. D., Professor in the Division of Otolaryngology, received his medical degree from Welsh National School of Medicine of the University of Wales and took his postgraduate training in Great Britain and at the University of Minnesota where he also served six years on the faculty. He comes to WVU from Case Western Reserve University.

George F. Kish, M. D., Assistant Professor in the Division of Thoracic and Cardiovascular Surgery, was formerly on the faculty of the George Washington University School of Medicine where he also received his postgraduate training.

Additions to the Division of General Surgery are Drs. Howard H. Harris, Ronald A. Savrin and Peter L. Villani.

Doctor Harris is a graduate of Trinity College in Connecticut and received his medical degree from the University of Missouri. He completed his postgraduate training in surgery at the University of Indiana Hospitals.

Doctor Savrin, a graduate of the University of Rochester and State University of New York School of Medicine, served his surgery residency at Ohio State University.

Doctor Villani, who was born in Welch, is a graduate of the University of Richmond and the WVU School of Medicine. He received his postgraduate training at Roanoke Memorial Hospitals and the University of Virginia Hospital.

Hematology - Oncology Chairman

Named below are some of the new faculty members who have been added to the Department of Medicine.

Peter C. Raich, M. D., Professor of Medicine and Chairman of the Division of Hematology-Oncology, was formerly Director of the Clinical Hematology Laboratory and an attending physician at the affiliated hospitals of the University of Wisconsin.

James D. O'Toole, M. D., Professor, named to the faculty of the Division of Cardiology, comes to WVU from the University of Pittsburgh where he was Co-Director of the Cardiac Diagnostic Laboratories.

Also in the Division of Cardiology is Soad Bekheit-Saad, M. D., Associate Professor. A graduate of the University of Cairo, Doctor Bekheit-Saad completed her postgraduate training at Queen's University in Belfast, Northern Ireland.

Enayotollah Osanloo, M. D., Assistant Professor in the Division of Nephrology, is a native of Iran and was educated at the University of Teheran where he also received one year of postgraduate training.

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Third-Party News, Views and Program Concerns

Recommendations for Gonococcal PID Management

Editor's Note: The information below is directed to all state physicians, hospitals and county health departments from Mr. Ronald Bryant, Public Health Advisor, Bureau of Venereal Disease Control, West Virginia Department of Health.

Gonococcal Pelvic Inflamatory Disease (PID) is becoming more and more frequently diagnosed by hospitals, physicians, and health departments. Below are current recommendations for gonococcal PID management. Please share this information with your private medical community.

1. Many women with PID seek care through a hospital emergency room or family physician. But more and more of these cases are being detected in public health facilities that do bimanual examinations. During this visit, a number of things must be done. The diagnosis of PID must be considered and confirmed through a bimanual examination. Specimens for a gonorrhea culture must be collected. A decision on in-patient or out-patient therapy must be made and a regimen that is appropriate for PID must be instituted.

2. In most instances, the distinction between gonococcal and nongonococcal PID can only be made when cuture results are available (usually within 48 to 72 hours). It is at this time that decisions about sexual partner referral can be made validly. We believe that women with gonococcal PID (PID plus positive gonorrhea culture) should be interviewed and their partners referred. We also believe that evidence does not at this time support the same active pursuit of the partners of women with negative cultures and a diagnosis of PID.

3. The progress of the patient should be clinically assessed within three to five days after the initial visit. This assessment requires taking additional history and repeating the bimanual examination. This evaluation can be done at a hospital, a physician's office, or at the health department if the appropriate staff has been trained to offer these services. The sexual partner referral interview can be integrated into this visit.

4. A bacteriologic test of cure for those women who have gonococcal PID should be performed at 13-17 days after the initial emergency room visit. A longer interval after the initial visit is selected because recommended out-patient regimens for pelvic inflamatory disease are of 10-day duration. This evaluation should also include history, a repeat bimanual examination, and gonorrhea cultures from the cerevix and anal canal.

5. Additionally, a rescreening test four to six weeks post-treatment is appropriate to detect women who are reinfected with gonococci. Such reinfected patients may be more prone to a repeat episode of PID, each with a worse prognosis.

Panel Believes Sunscreen Products Can Help

An expert advisory committee appointed by the United States Food and Drug Administration has concluded that proper use of sunscreen products to prevent sunburn may protect against premature aging of the skin and possibly skin cancer.

The panel recommended that all sunscreen products say on the label: "Overexposure to the sun may lead to premature aging of the skin and skin cancer. The liberal and regular use of this product may reduce the chance of premature aging of the skin and skin cancer."

The panel further recommended that the FDA require all sunscreen products be rated for the consumer according to their ability to protect the skin. Under the panel's recommendation, sunscreens would carry rating numbers from two to eight: products with the highest number would provide the maximum protection.

Several manufacturers now market sunscreen products that are labeled to suit different consumer needs, according to the panel's report.

AFRICAN ADVENTURE

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Obituaries

ALBERT L. ALLEN, M. D.

Dr. Albert L. Allen of Winchester, Kentucky, formerly of Huntington, died on August 11 in Birmingham, Alabama, following heart surgery. He was 71.

A radiologist, Doctor Allen formerly practiced in Huntington where he was affiliated with Dr. Charles E. McKay, Jr., and the late Drs. Cole D. Genge and Howard R. Crews.

A former member of the Cabell County Medical Society and the West Virginia State Medical Association, Doctor Allen was a native of Spartanburg, South Carolina. He received his M. D. degree in 1933 from the Medical College of the State of South Carolina, completing an internship in Florida and a residency at Duke University.

He also did postgraduate work at the University of North Carolina, the University of Liverpool in England, and the University of Pennsylvania.

Certified by the American Board of Radiology, he also had practiced in Louisa, Ashland, Richmond and Winchester, Kentucky.

During World War II, Doctor Allen served with both the United States Medical Corps and the Royal Army Medical Corps of Great Britain.

He was a member of the Kentucky Radiological Society, the American Radiological Society and the American Medical Association.

Surviving is the widow, Mrs. Julia Winn Allen of Winchester.

* * *

MARVIN H. PORTERFIELD, M. D.

Dr. Marvin H. Porterfield of Martinsburg, a surgeon, died on August 25 in a hospital there. He was 83.

Doctor Porterfield was a Past President and Secretary of the Eastern Panhandle Medical Society, and former Vice President and member of the Council of the West Virginia State Medical Association. He also was a former Chief of Staff at King's Daughters Hospital in Martinsburg.

A native of Martinsburg, Doctor Porterfield was graduated from Shepherd College and received his M. D. degree in 1917 from the University of Maryland School of Medicine.

Immediately after internship at Franklin Square Hospital in Baltimore, he entered the

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***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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OBITUARIES—Continued from page xvi

U. S. Army Medical Corps, serving as an officer until the close of World War I, when he opened private practice in Martinsburg.

Doctor Porterfield interrupted his career twice again for military service. During World War II, he was on active duty in the U. S. Navy Medical Corps from January, 1942, until the end of that war. During the Korean War, he was again on active duty in the U. S. Navy Medical Corps. At the time of his retirement from the Navy, he was Director of Medical Reserves at the Bureau of Medicine and Surgery in Washington, D. C.

Doctor Porterfield was a former state President of the American Legion and B. P. O. Elks.

Surviving are one son, Marvin H. Porterfield, Jr., of Martinsburg, and one daughter, Mrs. Todd Butler, also of Martinsburg.

* * *

O. H. BOBBITT, M. D.

Dr. O. H. Bobbitt of St. Petersburg, Florida, formerly of Charleston, died on August 26 in St. Petersburg. He was 93.

A native of Nicholas County, Doctor Bobbitt practiced in Charleston from 1921 to 1958. He specialized in the eye, ear, nose and throat.

He was an honorary member and Past President of the Kanawha Medical Society, and an honorary member of the West Virginia State Medical Association and the American Medical Association.

Doctor Bobbitt also practiced in Vaughn (Nicholas County), Summersville and Widen (Clay County) before going to Charleston.

He received his M. D. degree in 1914 from the University of Maryland School of Medicine.

Survivors include the widow: a daughter, Mrs. William E. Baldock of Columbus, Ohio, and two sisters, Mrs. Lola Summers of Gauley Bridge and Mrs. Arthur Flentji of Huntington.

* * *

THOMAS C. McFARLAND, M. D.

Dr. Thomas C. McFarland of Huntington died on August 12 in a hospital there. He was 58.

Born in Cincinnati, Doctor McFarland was graduated from West Virginia University and received his M. D. degree in 1944 from Temple University School of Medicine. He interned at Germantown Hospital in Philadelphia and completed a residency at St. Mary's Hospital in Huntington.

A veteran of World War II, he was a member of the Cabell County Medical Society, the West Virginia State Medical Association and the American Medical Association.

Survivors include the widow; a daughter, Ann Crowley McFarland, at home, and one son, James Michael McFarland of Murfreesboro, Tennessee.

* * *

WALLACE B. MURPHY, M. D.

Dr. Wallace B. Murphy of Grafton, who completed a two-year term on the Council of the West Virginia State Medical Association in August, died on September 10 in a hospital there. He was 70.

Doctor Murphy, who attended the Association's 111th Annual Meeting this past August at the Greenbrier, did not run for re-election to the Council because of illness.

A surgeon, Doctor Murphy was graduated from West Virginia University and received his M. D. degree in 1930 from New York University School of Medicine in New York City. He interned at Bellevue Hospital in New York City and did postgraduate work at New York University.

A native of Grafton, Doctor Murphy was a member of the Tygart's Valley Medical Society, the West Virginia State Medical Association and the American Medical Association.

Survivors include the widow; and three daughters, Mrs. Donald Dinnhaupt of Madison, New Jersey; Mrs. John Teahan of Fairmont, and Mrs. Lorne Norton of New York City.

* * *

EDWIN R. McCOY, M. D.

Dr. Edwin R. McCoy of Statesville, North Carolina, formerly of Charleston, died on August 9 in a Statesville hospital. He was 62.

Doctor McCoy was retired Head of the Obstetrics and Gynecology Department at Davis Hospital in Statesville.

He was associated with Golden Memorial Clinic in Elkins from 1951 to 1955, and was on the staff of Staats Hospital in Charleston from 1955 to 1961.

A veteran of World War II, Doctor McCoy was a former member of the Kanawha Medical Society and the West Virginia State Medical Association.

Survivors include the widow; one son, Richard McCoy of Matthews, North Carolina; two daughters, Mrs. R. S. Griggs of Alexandria, Virginia, and Mrs. Robert Ammons of Mooresville, North Carolina; two stepsons, James C. Moody

of Clemmons, North Carolina, and Evan R. Moody of Newark, Delaware, and two sisters, Mrs. Edgar T. Higgens of Summit, New Jersey, and Mrs. Samuel G. Williams of Jacksonville, Florida.

* * *

J. PRESTON LILLY, M. D.

Dr. J. Preston Lilly, retired Charleston obstetrician and gynecologist, died on August 20 at his home. He was 82.

A native of Flat Top (Mercer County), Doctor Lilly retired in 1972.

Doctor Lilly was graduated from Concord State Normal School (now Concord College) and attended West Virginia University. He received his M. D. degree in 1923 from the Medical College of Virginia.

He interned at Monongalia County Hospital in Morgantown and did postgraduate work in New York City and Vienna, Austria.

A veteran of World War I, he was an honorary member of the Kanawha Medical Society, the West Virginia State Medical Association and the American Medical Association.

Survivors include the widow; a daughter, Mrs. Margaret Jane Hill of St. Petersburg, Florida, and a sister, Mrs. Edward A. Carr of Narrows, Virginia.

Radiology:
John A. Lind, M. D.

Pathology:
Fulvio Fronyutti, M. D.

Surgery:
Hu C. Myers, M. D.
A. Kyle Bush, M. D.
J. W. Woodford, M. D.
Dovid C. Snyder, M. D.

Gynecology and Obstetrics:
Raymond W. Cronlund, M. D.

Internal Medicine:
E. G. Guy, M. D.
B. G. Thimmappa, M. D.
Karl J. Myers, Jr., M. D.

Ophthalmology:
Nirmol Konol, M. D.

Pediatrics:
E. G. Kreider, M. D.
J. M. Nissley, M. D.

Dentistry:
Glenn B. Poling, D. D. S.

Lonnie L. Crone
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County Societies

MONONGALIA

The Monongalia County Medical Society met on June 6 at the Ramada Inn in Morgantown.

Dr. Gene L. Budig, President of West Virginia University, presented a very interesting talk regarding the University and its role in the state.

The Secretary announced the acknowledgement of a gift of $280 to the AMA-ERF which is designated for WVU School of Medicine. She also announced the dedication of the Quiet Room at the Monongalia General Hospital on June 17. —Barbara Jones, M. D., Secretary.

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Resolutions

Editor's Note: Here is a complete text of resolutions *adopted*, in the form in which they were approved finally, at the second and final session of the House of Delegates during the West Virginia State Medical Association's 111th Annual Meeting August 23-26 at the Greenbrier in White Sulphur Springs:

Resolution No. 2 — West Virginia Medical Institute, Inc.—By The Kanawha Medical Society.

WHEREAS, There have been numerous complaints arising among the medical profession regarding the administrative operations of the West Virginia Medical Institute, Inc.; and

WHEREAS, Attempts by some participants of the Institute and some local medical societies seeking remedy for these problems have failed to meet with success; and

WHEREAS, It is our understanding that a full-time Medical Director is a prerequisite for the operations of the Institute;

THEREFORE, BE IT RESOLVED, That the West Virginia State Medical Association go on record as recommending the employment of a full-time Medical Director by the West Virginia Medical Institute, Inc.; and

BE IT FURTHER RESOLVED, That a copy of this resolution be directed to the Board of Directors of the West Virginia Medical Institute, Inc., and to any other interested parties.

Resolution No. 3—Licensing of Physicians—By The Kanawha Medical Society.

WHEREAS, The Medical Licensing Board of West Virginia is the recognized authority for the licensing of doctors of medicine and surgery in West Virginia; and

WHEREAS, The West Virginia State Board of Osteopathic Examiners is the recognized authority for the licensing of doctors of osteopathy for the practice of medicine and surgery in West Virginia; and

WHEREAS, The licenses granted by the Medical Licensing Board and the licenses granted by the Board of Osteopathic Examiners convey the same privileges, rights and responsibilities to physicians to practice medicine and surgery in West Virginia;

THEREFORE, BE IT RESOLVED, That the West Virginia State Medical Association's Executive Committee explore with the leadership of the West Virginia Society of Osteopathic Medicine the feasibility of adopting the Federation of State Medical Licensing Examination (FLEX) as the vehicle for licensure of all physicians practicing medicine and surgery in West Virginia.

Resolution No. 5—Physical Rehabilitation—By the Medical Economics Subcommittee on Vocational Rehabilitation.

WHEREAS, The West Virginia State Medical Association's Medical Economics Subcommittee on Vocational Rehabilitation has carried out comprehensive efforts to assure more effective care for the handicapped in this State, with such efforts including a study to document the need for a Physical Rehabilitation Center; and

WHEREAS, The Subcommittee has strengthened working relationships with the West Virginia Division of Vocational Rehabilitation toward realization of its goals; and

WHEREAS, The Division of Vocational Rehabilitation engaged a consultant to review thoroughly the administration of, and services offered at, the West Virginia Rehabilitation Center at Institute, such consultant being Richard D. Burk, M. D., Professor and Chairman, Department of Physical Medicine and Rehabilitation, School of Medicine, Wright State University, Dayton, Ohio; and

WHEREAS, Doctor Burk visited the Rehabilitation Center on October 19, 20 and 21, 1977; carried out an intensive study including interviews with all chiefs of treatment services, physicians, consultants and administrators; and prepared a consultation report listing 17 specific recommendations; and

WHEREAS, The West Virginia Board of Vocational Education, at an April 13 and 14, 1978, meeting instructed Mr. Thorold S. Funk, Director of the West Virginia Division of Vocational Rehabilitation, to request a resolution from the West Virginia State Medical Association hopefully endorsing Doctor Burk's recommendations for action he has anticipated would improve operations at the Rehabilitation Center; and

WHEREAS, The Medical Economics Subcommittee on Vocational Rehabilitation reviewed the

report and endorsed the recommendations, including one calling for employment at the Center of a full-time Medical Director, preferably a physician with training and experience in rehabilitation medicine, a step repeatedly urged by the Subcommittee; and

WHEREAS, The Subcommittee conveyed to Mr. Funk, through Robert L. Ghiz, M. D., its Chairman, on May 4, 1978, its endorsement of Doctor Burk's recommendations, specifically including appointment of a full-time Medical Director for the Rehabilitation Center, pending further consideration of these recommendations at the State Medical Association's Annual Meeting August 23-26, 1978;

THEREFORE, BE IT RESOLVED, That the House of Delegates of the State Medical Association add its endorsement of Doctor Burk's recommendations, particularly that calling for employment of a full-time medical director (physiatrist) at the Vocational Rehabilitation Center at Institute; and of the work done by the Medical Economics Sub-Committee on Vocational Rehabilitation; and

BE IT FURTHER RESOLVED, That the House pledge its, and the State Medical Association's continued support to all possible efforts to implement the recommendations of Doctor Burk.

Resolution No. 6—Medical Scholarships—By the Committee on Medical Scholarships.

WHEREAS, The Committee on Medical Scholarships met in annual session Saturday and Sunday, June 10 and 11, 1978, in Parkersburg to interview applicants for West Virginia State Medical Association Scholarships to West Virginia schools of medicine granting the M. D. Degree, and to conduct other business; and

WHEREAS, The Committee adopted a motion recommending an increase in the annual scholarship value from $1,250 to $1,500, to be effective with those recipients enrolled in first-year medical school classes in 1979-80, and for subsequent first-year classes;

THEREFORE, BE IT RESOLVED, That the House of Delegates of the West Virginia State Medical Association approve an increase from $1,250 to $1,500 in the annual value of medical school scholarships granted by the Medical Association, effective with those recipients enrolled in first-year medical school classes in 1979-80, and for subsequent first-year classes.

Resolution No. 7—Continuing Medical Education—By the Council.

WHEREAS, There currently are some 35 states with mandatory requirements for continuing medical education for relicensure to practice medicine and/or continued membership in state medical societies or associations; and

WHEREAS, The Medical Licensing Board of West Virginia, by resolution adopted at a July 10, 1978, meeting, pointed to continuing education as "one recognized way to assure continued clinical competence;" and

WHEREAS, The Medical Licensing Board, in that same resolution, recommended to the West Virginia State Medical Association that it "consider the development of a continuing education program for physicians . . . licensed to practice in West Virginia;" and

WHEREAS, Analysis of 703 questionnaires returned by West Virginia physicians in a comprehensive 1978 CME survey by Robert L. Smith, M. D., Assistant Dean, Continuing Medical Education, West Virginia University School of Medicine, indicated a preference for tying CME requirements to State Medical Association membership rather than to state relicensure; and

WHEREAS, The Medical Association Committee on Medical Education and Hospitals voted at an April 30, 1978, meeting to recommend to Council "that the Association recognize the importance of continuing medical education by establishing a system of recognition of voluntary participation of physicians in CME activities;" and

WHEREAS, The Committee has named an ad hoc group to develop a mechanism for implementation of the voluntary CME program; and

WHEREAS, The Committee effort followed House of Delegates action at the August, 1976, Annual Meeting calling for further Executive Committee study of steps toward implementing an earlier ad hoc committee recommendation that requirements for the American Medical Association's Physician's Recognition Award be adopted for continued membership in the West Virginia State Medical Association;

THEREFORE, BE IT RESOLVED, That the House of Delegates recognize the current work of the Committee on Medical Education and Hospitals as consistent with steps taken in a number of other states using the voluntary approach as

the initial basis for development of more formal types of CME programs; and

BE IT FURTHER RESOLVED, That the House of Delegates charge the Committee on Medical Education and Hospitals to continue development of a CME program for physicians licensed in West Virginia, with such program development to be consistent with Medical Association staff and budget capabilities for implementation and operation.

A Substitute Resolution for No. 8—Definition of Optometry—By the Kanawha Medical Society.

BE IT RESOLVED, That the West Virginia State Medical Association will testify in support of any legislation introduced in the West Virginia Legislature for the purpose of repealing the 1976 enactment broadening the definition of optometry.

Resolution No. 1 by the Kanawha Medical Society, proposing that the House instruct the Medical Association's Committee on Constitution and By-Laws to draft an amendment which would mandate that the Committee on Nominations submit at least two names for each office in the Association except that of President, was not adopted.

Resolution No. 4, also by the Kanawha Medical Society, proposing that one of the four four-year medical scholarships awarded by the Medical Association annually be given in the name of former State Health Director N. H. Dyer, M. D., likewise was not adopted. Instead, it was referred to the Executive Committee as a part of further study toward development of appropriate recognition of Doctor Dyer's long service.

The Committee on Resolutions, in its report to the House recommending this action, said it "fully recognized the long and valuable service provided by Doctor Dyer as West Virginia's Director of Health and agreed unanimously that the State Medical Association should recognize officially this service." It added:

"However, your Committee noted that the fund used by the State Medical Association for Medical Scholarships is designated in the By-Laws as the Charles Lively Memorial Scholarship Fund (in tribute to a late Executive Secretary of the Association). Your Committee did not feel it appropriate at this time to identify any scholarship from that fund in specific fashion."

General and Thoracic Surgery
Stephen T. J. Lee, M. D.
James A. Gardner, M. D.

Orthopedics
Clifford A. Stevenson, M. D.
S. A. Zahir, M. D.
Mario C. Ramas, M. D.
George Orphanos, M. D.
A. E. Landis, M. D.

Obstetrics-Gynecology
A. Ray Jacobson, M. D.
Mariamma Abraham, M. D.
N. Wayne Taylor, M. D.

Ophthalmology
Edward T. Liu, M. D.

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Preston C. Davis, M. D.
Joseph A. Maiolo, M. D.
Eugene Warvariv, M. D.
R. James Yates, M. D.
S. L. Bembalkar, M. D.
H. Maynard Bellamy, M. D.
Salvatore A. Pecoraro, M. D.

Pediatrics
P. B. Gogo, M. D.
Raquel S. Israel, M. D.

Radiology
Thomas L. Martin, M. D.

Clinic Manager
James P. Bland

Necrology Report

The following is a list of West Virginia physicians whose deaths have been reported to the West Virginia State Medical Association during the past year:

1977

Sept. 22	Robert J. Tchou	Williamson
Sept. 26	D. D. Hamilton	Mannington
Oct. 9	John H. Murry	Gary
Oct. 26	James S. Klumpp	Huntington
Nov. 1	Grover C. Morrison	Huntington
Nov. 11	Juan A. Nordelo	Man
Nov. 21	Charles F. Fisher	Houston, Texas
Nov. 23	D. Brown Barber	Charleston
Dec. 8	Robert D. Ketchum	Charleston
Dec. 15	Alexander M. MacKay	Forest Hills, Kentucky
Dec. 22	Charles W. Ward	Eccles

1978

Jan. 6	Archie L. Starkey	Sun City, Arizona
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Respectfully submitted,

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Aug. 23, 1978

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The West Virginia Medical Journal

Vol. 74, No. 11 November, 1978

Dupuytren's Contracture: Tord Skoog's Selective Aponeurosectomy

(A Report of Two Cases)

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Selective aponeurosectomy, as advocated by Tord Skoog, is an effective surgical treatment of Dupuytren's contracture. It is characterized by the identification and preservation of the transverse palmar ligament, *a structure not involved in the disease process. Not only does this render the operation less hazardous by protecting the subjacent neurovascular bundles, but healing time is accelerated and the results are cosmetically and functionally more pleasing. Two personal cases are discussed and photographic documentation is presented.*

Baron Guillaume Dupuytren (1777-1835),[1] one of the ablest and best-trained French surgeons of his time, was a renowned teacher as well as clinician. According to Percy, he was "the first of surgeons and the least of men," materially overwhelmingly successful, yet disliked and feared by many of his peers. He did much to enter the pages of history, yet remains well-known to us largely for one of his lesser accomplishments, namely, the definition, in 1832, of the peculiar flexion-deformity of the hand which ever since, and perhaps unfairly to Sir Astley Cooper,[2] has borne his name. A detailed discussion of the nature and incidence of this entity will not be attempted here.[2,3,4,5] Suffice it to say that the palmar aponeurosis and its prolongations and connections with the volar aspects of the deep fascial envelope of the proximal digital phalanges can become involved in a progressive process of cicatrization which Skoog[4] attributes to fibrillar ruptures within the aponeurosis in those individuals so predisposed ("certain biomechanical qualities of the connective tissue in general, demonstrated in brittleness and decreased elasticity of the fibrous elements, are essential . . ."[4]). The fundamental pathologic process is believed to obey the basic principles of scar formation and contracture. Tord Skoog defends the thesis that there uniformly exists a band of transverse fibers, deep to the well-known triangular aponeurotic fan. The latter seems to arise from the palmaris longus tendon (which is, however, inconstant!) and continues in the form of four "pretendinous bands" to the digital fascia, after giving off in the web spaces the "natatory" or superficial transverse metacarpal ligaments.

The *transverse palmar ligament*, about one centimeter in width and limited to the midpalmar region, is intimately related to the underlying paratendinous septae and forms fibrous tunnel systems as "separate anatomical structures." The

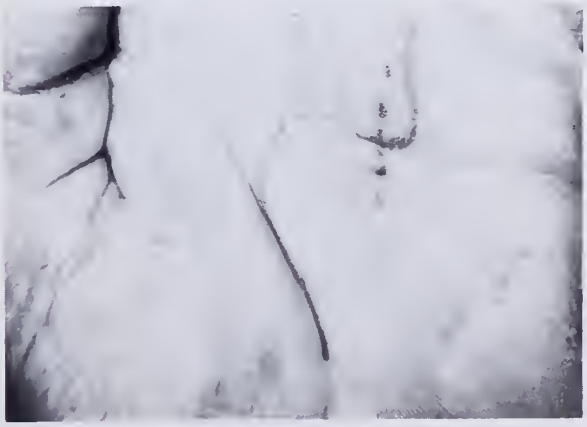

Figure 1. Skin incision outlined. Dotted line marks palpable hypertrophic band.

Figure 2. The skin flap has been elevated, the band divided and the slender, glistening transverse palmar ligament underneath has been exposed. Following excision of the contracted (superficial) band and preserving intact the transverse palmar ligament, the skin margins were reapproximated with fine nylon sutures.

transverse palmar ligament, encountered by Skoog in over 300 consecutive operations, was never found to be involved in the disease process, a circumstance the author explains on dynamic grounds: " . . . in no function of the hand are the fibres of this transverse band subject to tension or strain such as could reasonably be thought to cause them to rupture."[4] Contrariwise, the natatory ligaments can and do contract, at times markedly, thus adding the insult of digital adduction to that of flexion-contracture.

Accordingly, the Swedish surgeon introduced his modification of the standard radical aponeurosectomy, and by meticulously dissecting the longitudinal elements off the subjacent transverse ligament was able to (1) protect the neurovascular bundles; (2) preserve the subcutaneous fibro-fatty palmar tissues, especially the metacarpo-phalangeal fat pads; (3) maintain the transverse palmar arch, and (4) achieve a more functional and less paresthesia-prone hand.

Figure 3. Preoperative state with marked flexion contracture of ring finger.

Figure 4. Traction suture has been placed through pulp of fingertip and first skin incision made. Pneumatic tourniquet provides an entirely dry and bloodless field and is indispensable. The thickened cord has been exposed and is being incised. Its consistency is that of a tendon. The skin flaps have been sutured to the vicinity for improved exposure.

Recovery time was shortened from three weeks to 10 to 12 days and recurrences were not observed.

Two recent experiences with this insufficiently-known technique will be presented and the various operative steps illustrated with photographs obtained at the table.

Case One (Figures 1-2)

C. A. S.—This 57-year-old male had been admitted on November 15, 1976, to the Urology Service where a right ureterolithotomy was performed. For some six months, he had noted progressive and tender dimpling at the mid-metacarpal level of the palm of the left hand. A palpable, but not yet contracting aponeurotic band

Figure 5. The cord has been divided without damaging the underlying transverse elements. The longitudinal, contracted fibers will be excised proximally. Dissection is not carried laterally beyond affected regions! No unnecessary undermining of skin is done. The strongly developed transverse palmar ligament is demonstrated. A thin, protective fibroareolar layer of tissue is left in place. Neurovascular bundles are not disturbed.

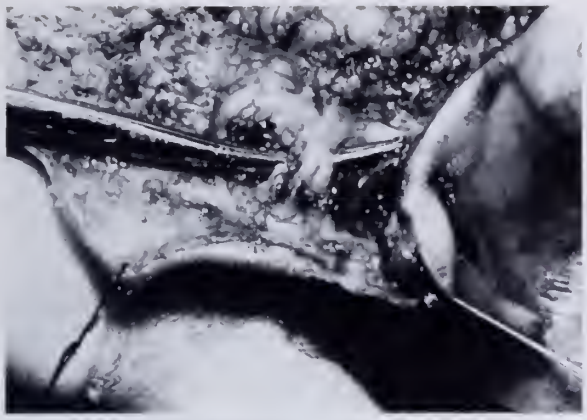

Figure 6. The superficial transverse metacarpal ligament is thickened and contracted: its division will free the little finger and restore its mobility (adduction!). Z-plasties are made along the volar and lateral aspects of the digit to allow full extension and exposure of the ENTIRE hypertrophic cord (McIndoe, Iselin).[6] Carefully identifying and protecting the neurovascular bundle (which can be dramatically displaced!) the thickened fibrous elements are pursued to their points of insertion and excised.

was present. On the right side there was a vague suggestion of an early nodule. The penis and soles of both feet were unremarkable. The lesion was Stage 3 according to Luck (1959).

Stage 1 describes the proliferative phase of fibroplasia.

Stage 2 describes the involutional or contracting stage wherein the nodule becomes smaller and puckers the skin, becoming anchored to an underlying tendon sheath or joint capsule.

Stage 3 describes the residual stage with contracted skin, fibrous cords and occasionally even joint contractures and tendon-shortening.

Selective aponeurosectomy was performed in a bloodless field on November 30, 1976. The postoperative course was unremarkable.

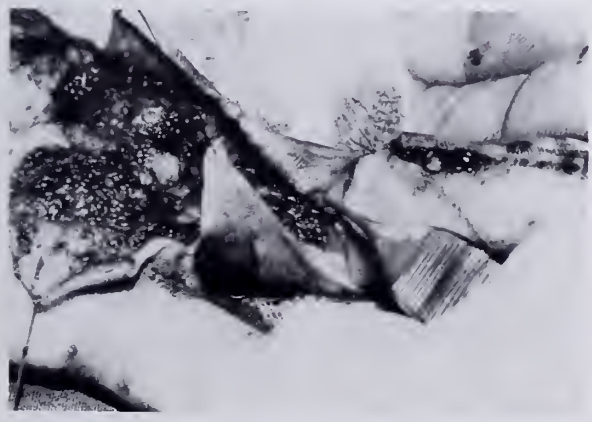

Figure 7. Passive finger extension results in neat and spontaneous "falling into place" of the triangular skin flaps.

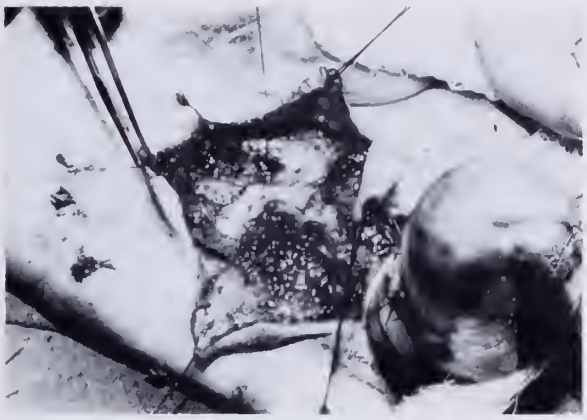

Figure 8. The palmar incisions are closed with fine nylon sutures incorporating portions of transverse palmar ligament so as to obliterate dead space and reduce tension.

Case Two (Figures 3-11)

G. R.—This 67-year-old gardener was hospitalized on March 11, 1977, with a disabling flexion contracture of the left ring finger. Maximal active extension was possible only to 135 degrees (Stage III/IV, Tubiana[5]). Significant adduction

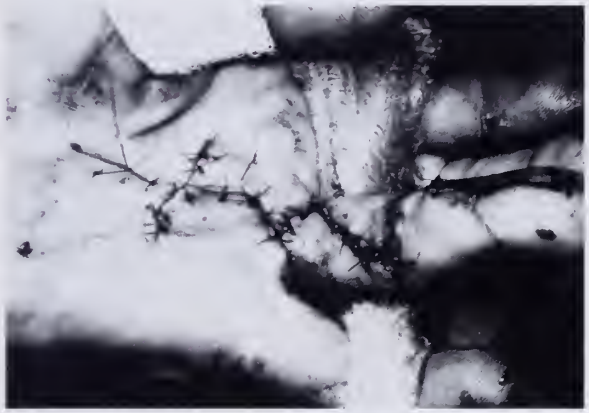

Figure 9. Basic incisions closed and Z-plasty accomplished.

Figure 10. Incision over palpable thenar cord reveals contracture of palmar fascia element leading into thumb. The hypertrophic cord has been incised.

Figure 11. Following excision of contracted fibrous elements the incisions have been closed with fine nylon sutures. Postoperative appearance of the hand. Ring finger remained pale at first, then dusky, but soon assumed a normal color and warmth. Sensation at fingertip was satisfactory. A "boxing glove" bandage was applied.

contracture of the little finger was present (contracted superficial transverse interdigital ligaments, "natatory" ligaments, superficial transverse metacarpal ligaments). Flexion contracture of the thumb was likewise noted. This patient had lost his right legt in 1944 and uses crutches. In 1975, his ring finger showed a 60-degree flexion contracture, the thumb one of 50 degrees. He elected to forego complete palmar fasciectomy on that occasion.

Selective aponeurosectomy was performed in a bloodless field on March 11, 1977, under general anesthesia. A boxing glove dressing was applied and initial IV pole elevation of the left hand was instituted.

Recovery was good despite early use of crutches and active utilization of the left hand. A small area of ischemic necrosis at the junction of the palmar and digital incisions healed uneventfully. Sensation remained good and finger extension was nearly normal. It is notable to record that amputation of the affected finger had been considered and was expected by the patient. He has full use of the hand as of this writing and is highly satisfied with the outcome.

Dynamic splinting was continued for several weeks, especially during the night hours. An excellent device for this purpose is the Levame splint, described by Iselin.[7]

Acknowledgement

I wish to express my sincere appreciation to Mr. Stanley Frum, Clarksburg Veterans Administration Hospital Photographer, for his assistance in this article.

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Lens Implant For Cataract: Analysis Of 200 Cases Using The Binkhorst Technique

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A historical resume of intraocular lens implant development is presented. The author's method is outlined. Results are presented showing a visual acuity result of 20/40 or better in 81 per cent of cases; marginal *or* partial failure *(20/50-20/100) in 9.5 per cent; and* total failure *(20/200 or less) in 7.5 per cent; with 2 per cent excluded from the total failure group because of known preoperative pathology which precluded a good visual acuity result. A discussion of results, failure and complications follows.*

THERE are three general types of intraocular lens (IOL) prostheses implantations in use today for aphakia of cataract. These are the anterior-chamber implant, the iris-fixated implant, and the capsular-fixated implant. In 1949, Ridley, in England, performed the first lens implant by putting plexiglas lens behind the iris, his so-called lenticulus.[1] Strampelli of Rome, in 1953, reported the first use of an anterior-chamber-placed implant,[2] implanting several hundred of these, but not without a large percentage of complications.[3] Choyce[4] of England continued to modify and sophisticate the anterior chamber implant, however, so that it has become the favorite of some eye surgeons today.[5]

The evolving experiences of Binkhorst, in the opinion of this writer, however, provide us with the best guide as to what a relatively safe, modern implant operation ought to be in the hands of the average eye surgeon. As early as May, 1956, he reported his experience first with the Ridley posterior chamber lens, which he abandoned because of technical difficulties in placing the bulky Ridley lenticulus behind the iris; and then with the anterior-chamber lens, the use of which he also subsequently abandoned because of technical difficulties in obtaining proper IOL anterior-chamber fit and because of corneal dystrophy which developed in 9 of 35 cases.[6] He then reasoned that an iris-fixated IOL would avoid corneal complications and subsequently reported 208 cases using this type of implant.[7]

The 20-year experience of Binkhorst[8] led him to state in 1976 the following: "The extra-capsular lens is a method of treatment of senile cataract that is safe enough to be generalized."[9] Using this method I have performed over 200 implants since 1974, and this paper deals with experiences in 200 cases done between November, 1974, and February, 1978.

Method

All cases involved patients with involutional (senile) cataract, with the criteria for surgical acceptance being the usual ones for cataract surgery. A large reservoir of previously unoperated monocular cataract cases offered an especially favorable group of candidates in the beginning of the series. There was no age limitation for patient selection, and thus the youngest patient was 33 and the oldest 93. The median consisted of the usual 70 to 80-year age group.

Preoperative visual acuity was 20/400 or less in 170 cases (85 per cent), 20/200 in 21 cases (10.5 per cent), 20/100 in three cases (1.5 per cent), and 20/70 in six cases (three per cent). Virtually all cases were done under simple local anesthesia (99.5 per cent).

The IOL used in all cases was the 2-loop Binkhorst capsular-fixated lens with approximately one third having platinum iridium loops, one third having titanium loops, and one third having Supramid loops. The lens power used in the vast majority of cases was +19.50 diopters. If it was determined by history that the patient was a precataract myopic of four diopters or more, the IOL power was arbitrarily diminished by two or three diopters. Conversely, if the patient was a precataract hyperopic of four or more diopters, the lens power was raised by two or three diopters. Using this simple method of lens power selection, very few patients showed a postoperative ametropia of greater than four diopters.

Surgery was done with a Zeiss operating microscope set at 10X magnification. Following a limbal section of 150-165 degrees, the cataract was removed from the capsule, leaving the posterior and equatorial capsule *in situ*, and two peripheral iridectomies were made. In placement of the IOL an attempt was always made to place the inferior loop in the inferior capsular sac. Pupil dilatation was effected with topical 10 per cent phenylephine prior to surgery, and pupil contraction following placement of the IOL was effected with topical four per cent pilocarpine

during surgery. Section closure was made with interrupted sutures of 10-0 nylon.

Techniques employed, which were felt to minimize intraocular trauma and complications, were the use of the Binkhorst forceps, use of body temperature-balanced salt solution within the anterior chamber, avoidance of centration of the IOL once in the eye until anterior-chamber reformation had occurred, and meticulous placement of closure sutures. The use of air for anterior-chamber reformation was generally not felt to be an advantage.

The absence of pain following the day of surgery was felt to be a prognostic *sine qua non*, since its presence generally heralded unusual postoperative inflammation or endophthalmitis or hemorrhage. The patient was fully ambulatory following the day of surgery. Pupil dilation was used electively where posterior synechia seemed a problem, and topical dexamethasone four times daily seemed to assure a quiet eye while not manifestly interfering with wound-healing.

Discission. Discission, or incision of the posterior capsule, is a secondary operative procedure that may be necessary in as high as 30 per cent of cases.[10] Capsular opacity can be persistent from surgery onward due to residual lens cortex or hemorrhage, thus leading to fibrous opacification of the capsule. It can occur later, however, following an interim of relatively good visual acuity, in which case the capsule becomes corrugated and glazed in appearance, probably because of cicatricial fibrosis in the capsular equator. A discission was done in 36 of these cases, and four more are presently pending, thus giving an incidence of 20 per cent in this study.

TABLE 1
Visual Results

20/20	63	= Normal 81%
20/25	14	
20/30	85	
20/40		
20/50	14	Marginal
20/60	1	= Partial falure 9.5%
20/70	1	
20/80	2	
20/100	1	
20/200	3	= Total failure 9.5%
20/300	4	
20/400	3	
Finger count – 3′	3	
Hand motion – 2′	3	
Light perception	1	
No light perception	2	

Results

The visual acuity, while not the only measure of surgical outcome, nevertheless offers the most obvious index of surgical results. Table 1 shows the eyeglass-corrected visual acuity for 200 cases.

Poor visual acuity result: not failure. In these cases, a known preoperative condition existed which precluded good visual acuity result, but surgery was done with the expectation of visual improvement. Most were cases of mature cataract. Table 2 lists the preoperative condition and the postoperative visual result. If these cases are subtracted from the "total failure" group in Table 1 the total failure rate becomes an accurate rate of 7.5 per cent.

Partial failure. A partial failure may be regarded as one in which, in the absence of previous pathology, the corrected visual acuity is less than it might well have been.[11] In this study it is defined as visual acuity in the range of 20/60 to 20/100. Table 3 lists partial failure with causes and final visual acuity. There were five partial failures (2.5 per cent).

Total failure. A total failure in this study is defined as one in which the visual acuity result was 20/200 or less. There were 14 such cases (7.5 per cent). They as listed in Table 4 with their probable causes and results.

Complications. A complication in this study is defined as an untoward postoperative event which either required treatment or ended in diminished visual acuity, or both. Problems encountered during surgery are considered as operative problems, and are not included in this listing. There were 31 complications (15.5 per cent), which are listed in Table 5 along with the treatment and final visual acuity. Fourteen of the 31 achieved visual acuity of 20/50 or better and 17 obtained visual acuity of 20/60 or less.

TABLE 2

Case No.	*Preoperative condition*	*Final visual acuity*
50	diabetic retinopathy	20/200
61	congenital amblyopia	20/100
68	congenital amblyopia	20/200
71	macular atrophy	20/400
195	branch vein occlusion	20/200

Discussion

The reader may ask, "Why do a lens implant for cataract?" The immediate answer is that a IOL offers a superior means of visual correction. The inherent problems of aphakia, such as limitation of visual field and ring scotoma, are eliminated. Monocular aphakic problems such as image disparity and diplopia, previously only tenuously solved with contact lens-wear, are eliminated.

At present, there is insufficient data in the literature as to what is the best and safest implant method. Nevertheless, since fixation of the IOL within the eye is the primary concern, and since capsular fixation offers the surest method of fixation, this method may prove to be the most widely accepted in time. The experience of Binkhorst would seem to confirm this. In this study there were six cases (three per cent) of nonfixation or luxation of IOL. There were no cases of IOL touch-of-the-cornea causing corneal dystrophy, a not infrequent complication of the intracapsular method currently in vogue by many American eye surgeons.

One might question a major failure rate of 7.5 per cent (visual acuity of 20/200 or less). Kirby reported a five per cent failure rate for intracapsular cataract surgery before the advent of lens implants.[11] Callahan reported an incidence of 20/200 result or less in 16.5 per cent of a series of one-eye patients using modern intracapsular cataract technique prior to the implant era.[12] More recently, Taylor has reported a 20/200-or-less result in 6.2 per cent using intracapsular technique and iris-fixation implant methods.[13] By comparison, the results in this study appear acceptable.

TABLE 3
Partial Failures

Case No.	*Cause*	*Final visual acuity*
91	Inadequate capsulostomy following discission. Probable cystoid maculopathy.	20/60
120	Multiple discission procedures for capsular membrane. Probable cystoid maculopathy.	20/60
142	Retrobulbar hemorrhage following retrobulbar anesthesia injection for discission. Probable cystoid maculopathy.	20/100
169	Probable cystoid maculopathy and macular degeneration.	20/100
182	Capsular membrane. Probable macular degeneration.	20/80

A complication rate or untoward-event rate of 15.5 per cent encountered in this study indicates that lens implant surgery is not routine cataract surgery. Surgical reintervention for complication was necessary in 12 cases (six per cent). The most frightening of operative eye complications, endophthalmitis, occurred in an alarming 2.5 per cent of cases (Tables 4 and 5). Two of these ended grieviously with a no-light-perception eye; however, the remaining three made a good recovery. Certainly, this rate is many times higher than endophthalmitis in routine cataract surgery, where only a fraction-of-a-per-cent incidence is reported.[14]

Lens implant surgery, while presently still somewhat controversial, no doubt has an assured future. The present unprecedented investigative study by the FDA, while laborious and costly, will probably ultimately yield useful statistical data. Nonetheless, some hold the opinion that

TABLE 4
Total Failures

Case No.	*Cause*	*Final visual acuity*
20	Endophthalmitis-arrested. Dense capsular membrane. Patient killed in accident prior to discission.	20/400
47	Inferiorly displaced IOL and pupil spinchter rupture. Unsuccessful corrective surgery and probable maculopathy.	20/200
69	Capsular membrane. Patient deceased prior to discission.	20/200
74	Endophthalmitis.	No light perception.
108	Branch retinal vein occlusion involving macula.	Count fingers - 2′.
111	Anterior chamber hemorrhage with secondary glaucoma. Multiple glaucoma procedures.	Light perception.
115	Bullous keratopathy.	20/300
140	Cystoid maculopathy.	20/200
144	Senile macular degeneration.	20/300
159	Capsular membrane. Discission pending.	20/200
162	Bullous keratopathy following surgery for dislocated IOL.	Hand motion - 1′.
164	Capsular membrane. Multiple discissions. Probable cystoid maculopathy.	20/400
167	Anterior chamber hemorrhage resolving into capsular membrane. Bullous keratopathy.	Count fingers - 3′.
198	Endophthalmitis.	No light perception.

independent studies such as that reported by Taylor *et al* will prove more valuable.[15] Hopefully, this report will provide additional useful statistical data.

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TABLE 5

Complications

Case No.	*Complication*	*Treatment*	*Final visual acuity*
6	Nonfixation of IOL	Pseudophakopexy	20/40
20	(See Table 4)	Antibiotics	20/400
41	Anterior chamber hemorrhage. Secondary glaucoma.	Trabeculectomy	20/40
44	Iritis occurring more than 6 weeks after surgery	Steroids	20/20
47	(See Table 4)	Surgery	20/200
53	Iritis occurring more than 6 weeks after surgery	Steroids	20/40
60	Luxation of IOL into anterior chamber	Surgery	20/40
69	(See Table 4)	None	20/200
74	(See Table 4)	Antibiotics	No light perception
91	(See Table 3)	Surgery	20/60
99	Endophthalmitis	Antibiotics	20/30
108	(See Table 4)	None	Counts fingers - 3′
111	(See Table 4)	Surgery	Light perception
115	(See Table 4)	None	20/300
120	(See Table 3)	Surgery	20/60
123	Anterior chamber hemorrhage; capsular membrane.	Surgery pending	20/50
124	Cystoid maculopathy following discission	None	20/40
136	Endophthalmitis	Antibiotics	20/40
138	Luxation of IOL	Surgery	20/40
139	Luxation of IOL	Surgery	20/20
140	(See Table 4)	None	20/200
142	(See Table 3)	Surgery	20/100
144	(See Table 4)	None	20/300
152	Probable cystoid maculopathy following discission	None	20/40
162	(See Table 4)	None	Hand motion acuity - 1′
164	(See Table 4)	Surgery	20/400
166	Iritis occurring more than 6 weeks after surgery	Steroids	20/40
169	(See Table 3)	None	20/200
182	(See Table 3)	None	20/200
197	IOL luxation into anterior chamber	Surgery	20/50
198	(See Table 4)	Antibiotics	No light perception

Aspects Of Early Detection Of Breast Cancer With Mammography And Other Procedures*

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The purpose of this paper is to put into perspective some of the recent problems pertaining to breast cancer diagnosis. Two methods of screening, mammography and thermography are discussed with a view of the benefits and possible hazards of both.

APPROXIMATELY 33,000 deaths due to cancer of the breast occur annually, while another 90,000 new cases are diagnosed each year. It is the leading cause of death in the 40 to 44 age group in females and, according to the American Cancer Society, one in six females will have a breast biopsy and one in 15 will develop breast cancer. Although rare under the age of 20 and uncommon under 30, the incidence increases rapidly so that 93 per cent of all breast cancers are detected in patients over 40.[1]

The purpose of early detection is to catch the disease in the localized phase where treatment can be most useful. It is commonly recognized that a one-centimeter mass is the smallest nodule which can be found on physical examination. Assuming that the neoplasm has begun from a single cell, several investigators have calculated a proliferation time of approximately eight years before it reaches one centimeter. During this eight-year period the tumor is in the preclinical phase. Once the cancer has reached the clinical stage it can be broken down into several divisions: the local phase, the local metastatic phase, and the metastatic phase, each proceeding with a poorer prognosis. To determine if preclinical detection is useful, it is necessary to determine if those patients with early-found cancers actually live significantly longer than those found later. However, care must be taken not to bias one's results, because early-detection patients may simply have a longer observation time with the disease.[2]

Thermography vs. Mammography

One type of screening procedure which has been employed is thermography. The thermogram is a relatively simple procedure in which the heat given off by the patient's body is measured without exposure of the patient to radiation. Some criteria for an "abnormal" thermogram of the breast are given as follows: (1) a "hot" spot is an abnormal finding (>1.5°c above normal body temperature); (2) a localized, increased vascularity is present; (3) increased heat in the areolar area, and (4) or a generalized increase in the breast temperature.

In the study shown in Table 1, however, thermography failed to pick up a significant number (40 per cent) of malignancies when compared to mammography.

Thermography lacks precise localization information, and the relative nonspecificity of the procedure will prevent biopsy on this basis alone. Therefore, if used, it should only be a screening procedure for mammography.

A study group headed by surgeon Oliver Beahrs, and radiologists Richard Gold and Justin Stein has recommended to the National Cancer Institute (NCI) that thermography be discontinued as a part of Breast Cancer Detection Demonstration Projects. However, the group also urged that a few centers with favorable results from thermography be allowed to continue the modality with added support for research and improvement.[7]

TABLE 1

Thermography vs. Mammography[3]

Procedure	*Total Number*	*Histological Proven CA*	*Premalignant Lesion*	*Benign Lesion*	*Neg. Biopsy*
Thermogram + Mammogram +	108	70=64.8%	30=27%	7=6.9%	1=0.5%
Thermogram − Mammogram +	40	16=40%	1=2.5%	21=52.5%	2=5%

*This paper was written while Mr. Wisman was a second-year medical student.

TABLE 2

Axillary Nodes	*5-Year Survival*	*10-Year Survival*
Nodes Negative—270	85%	70%
Nodes Positive—367	46%	29%

In the case of mammography, the most widely utilized screening program has been that of the Health Insurance Plan (HIP) of New York. About 20,211 patients were screened with both radiographic and physical examinations. The detection rate was 2.72/1,000; however, in the control group of 94,660 the rate was only 1.45/1,000, indicating that nearly twice the number of breast carcinomas were picked up in the screened group. The HIP program further showed that of 132 cases detected by screening 33.3 per cent were found by mammography alone, 44.7 per cent by clinical examination alone and 22 per cent by both modalities. Without mammography as an adjuvant to physical examination, about one third of the cases would have slipped by. By screening with mammography the cure rate of the study group was increased by a factor of 6.3/10,000 as compared to the control group. Interestingly enough, 65 per cent of the study group, on examination, had no signs of axillary node involvement as compared to 44 per cent of the control group. Of the cancers detected by mammography alone (33 per cent), 81 per cent had no node involvement as compared to 61 per cent of those detected by physical examination alone. The data from Emory University (Table 2) points to the importance of axillary node-involvement when looking at the survival rate of the patient.[1]

On the basis of the preceding information, confidence can be placed in mammography as a useful tool for the detection of breast cancer in complement with a physical examination. If mammography is to be used as a screening technique, however, a certain balance must be struck between the benefits and detriments.[6]

The principal drawback is the threat of excessive radiation. It has been estimated that approximately six malignant lesions will be produced per one million women exposed to one rad to the breast per year. Indeed, NCI Director Arthur C. Upton, in July, 1977, estimated that one rad to the breast would add one per cent to the natural risk of breast cancer in women. With the natural risk fixed at seven per cent, a single mammogram would increase it to 7.007 per cent.[7] Table 3 indicates that even with the use of xeroradiography and low-dose mammography, a patient having a mammographic examination will incur much more than one rad per year.[8]

A new low-radiation technique for film mammography (mini-dose) using vacuum pack procedures has been compared to the low-dose system with favorable results. The radiation exposures are 0.68 rads for the mini-dose and 1.57 rads for the low-dose film-per-film. Thus, a 57 per cent radiation exposure reduction was noted. Nevertheless, problems with exposure still exist when considering screening programs.[9]

One solution to this dilemma is a scheme to select those persons who are at a high risk and then make a screening program available to them.

The major risk category includes those women with:

Prior cystic disease (2.5 x normal incidence)

Prior history of breast cancer (6x)

Family history of breast cancer (2.5x)

Lump in the breast

Nipple discharge

The minor risk category includes:

Menarche prior to age 12

No birth before age 30 of a live child[10]

Also, the age of the patient must be taken into consideration. Since only three per cent of all breast cancers occur under 35 and malignancies are hard to detect in the young, dense breast, it would seem unwise to submit younger women to annual radiation exposure.[5] One clinical study, however, recorded 6.4 per cent of breast cancers are found in the 35 to 39 age group and 55 per cent are found in the 40-49 age group. This would mean that 61.4 per cent of breast cancers would be missed if screening projects started at age 50.[3]

TABLE 3

Exposure Factors in Mammographic Technique

Method	*Peak KV*	*MA-Sec*	*Dose/Exposure/Breast*	*Target*
Conventional	28-32	1200-1800	4.0 - 6.0 RADS	Tungsten
Low-Dose	28-32	125	1.5 - 2.5 RADS	Moly
Xeroradiography	36-44	300	1.5 - 2.5 RADS	Tungsten

TABLE 4
Diagnostic Mammographic Accuracy[5]

		Histopathologic Diagnosis					
		Benign Radiographic Diag.			Malignant Radiographic Diag.		
Authors	*Cases*	*Malig.* (%)	*Benign* (%)	? (%)	*Malig.* (%)	*Benign* (%)	? (%)
Clark	1580	10	90	–	79	21	–
Egan	1217	9	91	–	97	3	–
Friedman	776	9	75	16	68	18	13
Ingleby	536	0.5	65	35	63	3	24
Wolfe	759	12	88	–	92	8	–

If a screening procedure is initiated, the minimum age of participation should be 40; however, a mammogram would be indicated if one or more palpable, dominant masses are found regardless of age. Also, a prompt biopsy and histologic examination should be performed if the mammogram is suspicious in character. In such cases a mammogram may serve to confirm the physical findings, to provide additional information to the nature and extent of the disease, and/or to localize the lesion with a needle for prompt biopsy. Women with breast symptoms such as localized pain and tenderness should not be readily considered for biopsy, but a mammogram may be ordered at the physician's discretion for both older patients and younger ones in the high risk group.[5]

Benign vs. Malignant Tumors

Several authors have published their radiological accuracy of mammographic interpretation as correlated with pathological diagnosis (Table 4).

The benign lesions comprise a diverse, poorly understood group of abnormalities which present a varying radiographic appearance. Pathologically, these lesions range from diffuse bilateral alterations in the stromal and glandular components

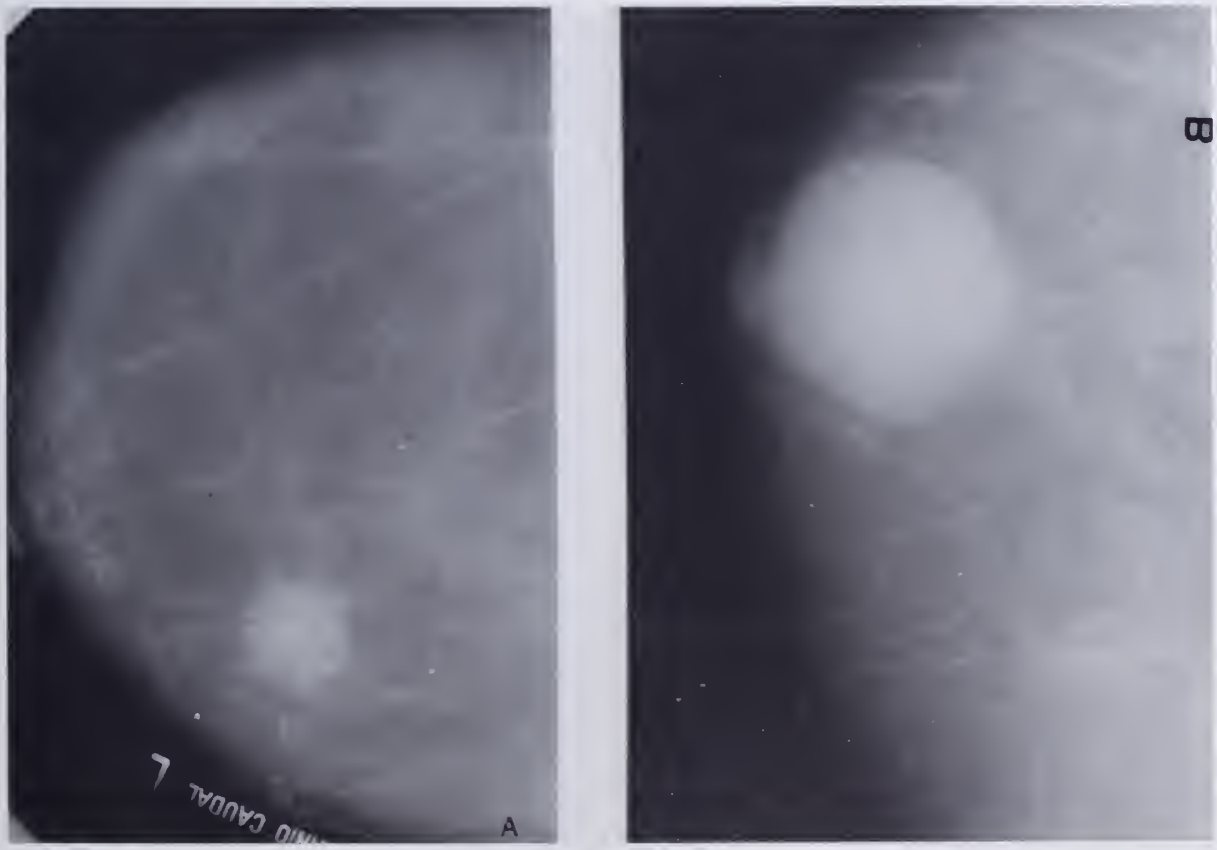

Figure. The lesion in A demonstrates the irregular shape, numerous spicules, irregular margins and variable density of a malignant lesion, while the lesion in B has the smooth, regular, distinct borders and homogenous density throughout which are typical features of a benign lesion.

of the breast to solitary or discrete lesions which appear to arise in otherwise normal breast tissue. Most of the discrete lesions, e.g., fibroma and localized cyst, present well-defined and distinctive radiographic appearances. Among the diffuse benign lesions, radiographic characteristics tend to be nonspecific and difficult to describe. Indeed, some benign lesions mimic cancer in almost every radiographic aspect. The most common benign abnormality of the breast is fibrocystic disease, characterized by stromal tissue overgrowth, cystic dilatation of ducts, and cyst formation.

Malignant tumors of the breast present radiographic features which are, for the most part, characteristic and readily identifiable on the mammogram. Infiltrating ductal carcinoma (scirrhous carcinoma) is associated with various amounts of fibrosis and is the most common form of carcinoma found in the breast from both a radiographic and pathologic standpoint. Both direct (primary if you will) and indirect (secondary) signs of malignant disease are seen on the mammogram (Figure).

Primary radiographic signs of malignancy are:

1. *Shape*: irregular rounded, discrete mass.

2. *Density*: variable, nonhomogeneous, more dense in the center.

3. *Margins*: irregular and indistinct, with spicules of tumor radiating outward, which produces a "sunburst" appearance.

4. *Pattern of Growth*: invasive and poorly circumscribed. This distorts and destroys the architectural pattern of normal surrounding tissue.

The indirect or secondary signs of malignant disease are abnormalities which represent changes in the breast associated with tumor. Some of the secondary changes are:

1. Calcifications in the carcinoma—roughly one third are demonstrated mammographically while 60 to 75 per cent are calcified or histologically inspected. Unlike the benign calcifications, these are irregular in outline, variable in size, and are confined to the tumor.

2. Thickening of the skin.

3. Enlargement of mammary veins (increased vascularity).

4. Retraction of skin and nipple as a result of the shortening and thickening of suspensory ligaments due to invasion by the tumor.

5. Axillary lymphadenopathy.

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Medical Grand Rounds

From the West Virginia University Hospital

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High-Density Lipoproteins: Possible Protective Factor Against Atherosclerosis

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High-density lipoproteins (HDL) have emerged as a strong reverse-risk factor of arteriosclerotic heart disease (ASHD), independent of other known risk factors such as low-density lipoproteins (LDL) cholesterol. It is quite possible that the somewhat variable association of elevated plasma triglycerides with ASHD is mediated by the negative correlation between triglycerides and HDL. While little is known of the regulation of HDL the most prudent physiologic approach to raising HDL at the moment would seem to be to institute measures to lower triglycerides, to prevent smoking, and to promote weight reduction and exercise.

ELEVATED serum cholesterol has long been recognized as a strong risk factor for arteriosclerotic heart disease (ASHD).[1] Yet cholesterol, even when combined with other risk factors such as hypertension, smoking, hypertriglyceridemia, obesity and diabetes, accounts for only a fraction of the risk of ASHD. After age 50, total cholesterol is not a predictor of ASHD at all. Both old and new information suggest that the predictive value of cholesterol can be improved if it is broken down into the fractions in which it is carried: very-low-density lipoproteins (VLDL), low-density lipoproteins (LDL) or high-density lipoproteins (HDL). Cholesterol and other lipids circulate in these lipoproteins of varying atherogenicity. Despite old information that HDL are decreased in ASHD[2,3] and that elevation of the HDL fraction might thus be beneficial, most studies aimed at lowering ASHD attack rate have focused on total cholesterol. Little, if any, reduction of ASHD has resulted from drug and dietary treatment of hyperlipidemia.[4,5]

In the last few years there has been an enormous renewal of interest in the possible protective effect of alpha or high-density lipoproteins (HDL). Miller *et al*, in 1975, reviewed evidence that HDL was a "negative" risk factor.[6] A list of conditions associated with low or high HDL respectively is shown in Table 1.[6,7,8] Increased ASHD is found in those conditions associated with low HDL (Table 1). Numerous epidemiologic studies, both retrospective and prospective, have confirmed the negative correlation between HDL levels and ASHD.[9-15]

TABLE 1
Conditions Associated with High and Low HDL[6,7,8]

HDL Decreased	*HDL Increased*
Males	Females
Ischemic heart disease	Absence of ischemic heart disease
Sedentary	Physically Fit
Urban Danes	Rural Eskimos
Increased LDL (cholesterol)	Decreased LDL
Increased VLDL (triglycerides)	Decreased LDL
Diabetes	Nondiabetes
Obesity	Thinness
Stroke	
Renal Disease	

*Reasearch Career Award 5 K06 HL00486, National Heart, Lung and Blood Institute.

Analysis of the data from the cooperative lipoprotein phenotyping study revealed that while LDL and VLDL (or triglyceride) were risk factors, HDL was a powerful negative factor, independent of other known risk factors including total cholesterol, LDL and triglycerides.[9] Low HDL was the most powerful single independent risk factor for ASHD. HDL was protective at all ages and in both sexes.[9] On the converse side, familial elevation of HDL is associated with longevity.[16] While it may be premature to conclude that HDL does indeed protect against ASHD, the overwhelming epidemiologic evidence suggests that the possibility should be taken seriously and that every effort should be made to delineate the mechanism of the protective effect and to find means of increasing HDL levels.

Physiologic Role Of HDL

In order to review the current thoughts on the physiological actions of HDL, it is necessary to review the classification of lipoproteins. There are four main categories of lipoproteins: chylomicrons, very-low-density lipoproteins (VLDL), low-density lipoproteins (LDL), and high-density lipoproteins (HDL). The relative composition and characteristics of these four classes are given in Table 2.[17] Triglyceride is the chief component of chylomicrons and of VLDL, while cholesterol is prominent in LDL and phospholipid predominates in HDL. It is to be noted that particle size and triglyceride content decrease while density increases from left to right.

Current evidence supports the concept that plasma lipoproteins are first delivered to the circulation as triglyceride-rich particles, either chylomicrons from dietary fat, or VLDL endogenously synthesized in the liver from carbohydrate or other precursors.[18] The triglyceride is then rapidly removed at the endothelial surface of capillary networks under the influence of the enzyme lipoprotein lipase. The enzyme cleaves the triglyceride molecule into free fatty acids and glycerol. One of the apoproteins of VLDL, apo-C II, is a cofactor for the reaction. The fatty acid is taken up by adipose tissue, reconstituted into triglyceride and stored. As the VLDL or chylomicrons become smaller and smaller, they become relatively richer in cholesterol. The end product of the degradation is low-density lipoproteins, LDL, the cholesterol-rich molecule thought to be directly responsible for the atherogenic process.[19] Most, if not all, circulating LDL may be derived from just such degradation of chylomicrons or VLDL.

Lipoproteins consist of a core of nonpolar lipids such as triglycerides and cholesterol esters, and a surface coat of polar substances such as free cholesterol, phospholipids, and proteins known as apoproteins. As the nonpolar triglyceride core of the VLDL shrinks, there is need for the polar surface components to be removed in order for the normal spherical structure of the lipoprotein molecules to be maintained. One of the functions of HDL is to act as a receptor, or temporary reservoir, for these surface elements of HDL.[19a] Perhaps in this or other ways HDL assists in the normal degradation of VLDL. The inverse relationship between VLDL and HDL[6] may indicate that high HDL concentration results from brisk degradation of VLDL.

Any factors which interfere with the normal degradation of chylomicrons or VLDL would thus be expected to reduce the size, and probably number, of HDL molecules. Thus, congenital lack of lipoprotein lipase, as in type 1 hyerlipidemia, is associated with a block in the metabolism of chylomicrons, and as would be expected, with low concentrations of HDL.[17] Factors which stimulate lipoprotein lipase such as heparin injection cause an increase in HDL. The universally reported negative correlation between VLDL (or triglyceride) and HDL is

TABLE 2

Lipoprotein Classes[17]

Term:	Chylomicron	VLDL	LDL	HDL
Electrophoresis:	Origin	Pre-beta	beta	alpha
Particle size, Å	750-10,000	300-500	200-220	75-100
Flotation rate Negative Svedberg Units, S_f	S_f400	S_f20-400	S_f0-12	
Density	0.94	0.94-1.006	1.016-1.063	1.063-1.210
Composition, %				
Triglycerides	90	55	10	3
Cholesterol	6	15	45	15
Phospholipids	3	20	20	30
Protein	1	10	25	50

explained by this hypothesis. Indeed, a positive correlation has been reported between the concentration of lipoprotein lipase in adipose tissue and circulating HDL concentration.[20]

Mechanism Of Protective Action Of HDL

In addition to its possible role in the degradation of atherogenic lipoproteins, HDL may be protective in three chief ways. First, HDL has been shown to act as an effective receptor of free cholesterol from tissues. Free cholesterol from the cell surface is readily transferred to the surface of the circulating enzyme lecithin-cholesterol acyl transferase (LCAT). Apo A1, the chief apoprotein of HDL, catalyzes the reaction. The resulting nonpolar cholesterol ester is transferred to the central core of the HDL molecule, leaving a vacant spot on the surface of the HDL molecule enabling the uptake of a new free cholesterol molecule. HDL could act as the chief means of removing excess cholesterol from tissues, including arteries.[21] Through the LCAT reaction, such cholesterol would be esterified and ultimately excreted by the liver. Miller *et al* found an inverse correlation between total body cholesterol pool and the level of circulating HDL, evidence favoring the removal hypothesis.[6] Tissue culture studies also support this hypothesis. Incubation of tissue with HDL causes removal of cholesterol from the tissue.[22]

The second possible mechanism is inhibition of uptake of LDL cholesterol by peripheral tissues.[23] The chief mode of disposal of LDL cholesterol is thought to be mediated by binding of LDL as specific binding sites in peripheral cells.[19] The binding and uptake of cholesterol-rich LDL could lead to atherogenesis, cholesterol being the most likely ultimate atherogenic substance. HDL also binds with the LDL receptor site, thereby constituting a competitive inhibitor for LDL binding. Unlike LDL, HDL, once bound, is poorly internalized and degraded following such binding. HDL would thus prevent LDL uptake, but would not itself serve as a source of intracellular cholesterol. Both of these theories have considerable experimental support.

A third possibility is that HDL is inversely correlated with an atherogenic subfraction of LDL, the latter being the cause of the apparent atherogenic effect of low HDL.[24]

Control Of HDL Concentration

The location of synthesis and degradation of HDL is poorly understood. Some knowledge of factors influencing the levels of HDL can be obtained from epidemiologic studies. Age does not seem to be an important factor; HDL may rise slightly with advancing age.[25] Sex has a major effect on HDL.[3,6] The reason for the lower HDL in men than in women is not known. The persistence of the sex difference into the postmenopausal age when women no longer have the advantage of excess estrogen suggests that estrogen does not account for the difference.[26] Exercise may have an HDL-raising effect, since HDL levels in runners are higher than HDL in sedentary, age-matched persons.[27] Prospective studies of the effect of exercise programs are needed.

Hypertriglyceridemia and obesity, both insulin-resistant states, are both associated with low HDL. Since lipoprotein lipase is an insulin-dependent hormone, such a negative association could indicate impaired action of lipoprotein lipase secondary to the insulin-resistance characteristic of these conditions.[28] The effect of diet on HDL is poorly understood. The "Prudent diet," low in fat and cholesterol and high in polyunsaturated fat and carbohydrate, caused a decrease in HDL,[29] while a higher-fat diet caused a reduction of triglycerides and an increase in HDL.[30] This has led to some concern that the "prudent" diet, while it might lower LDL cholesterol might also lower HDL cholesterol.

In a later, prospective study, Hulley *et al* found that HDL were rather resistant to change, being altered little, if at all, with implementation of a program aimed at lowering ASHD-risk factors for the MRFIT study.[31] Measures were taken in this study to decrease intake of saturated fat and cholesterol, to urge persons to stop smoking, and to correct hypertension. The factors contributing most strongly to change in HDL were change in triglycerides (a negative correlation, $P<0.001$), thiocyanate levels as an indication of smoking (a negative correlation, $P<0.01$), and alcohol intake ($P<0.05$). Other factors such as change in blood pressure, change in weight, change in cholesterol and change in serum glucose had no significant effect. The most startling finding of the study, however, was that all factors taken together accounted for only 10 per cent of the variance of change in plasma HDL. Clearly, HDL is resistant to change by methods aimed at lowering cholesterol. It is of interest that other studies have also found a positive association between alcohol intake, in moderate amounts, and HDL, though the meaning of this finding is unknown.[15,24,32] It is premature to conclude that alcohol will protect against ASHD by raising the HDL.

Drugs

Clofibrate and nicotonic acid have been reported to raise HDL.[32] While cholesterol binding

resins have little effect alone, when combined with nicotinic acid they lower LDL and raise HDL.[33] Estrogen raises HDL.[24] Birth control pills raise HDL and the effect is greater the greater the estrogen component of the pill, and less with a larger progestational component.[26] It is unknown whether the benefit to be gained from the HDL-raising effect is outweighed by the possible atherogenicity of its triglyceride-raising effect or its adverse effect of promoting platelet stickiness and vascular disease.

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Manuscript Information

Manuscripts to be presented for publication in *The West Virginia Medical Journal* should be typewritten, triple-spaced, on one side only of firm (no onion skin or flimsy), standard letter sized (8 1/2 by 11 in.) white paper. Wide margins (at least 1 1/4 in. on left) should be left free of typing. On the first or title page should be shown the title of the article, the name (or names) of the author, and his degrees. Pages should be numbered consecutively, the page number being shown in the right upper corner along with the surname of the author.

Where reference is made to generically-designated drugs, the first such reference must be followed by parentheses containing the most commonly known trade-name drug of that designation. In addition, a listing of all generic drugs mentioned in the article, with their trade-name equivalents, should appear at the end of the article.

A short abstract summarizing the manuscript should be included. This should be typed in double space on a separate page.

Authors are requested to submit a carbon copy with the original.

Illustrations should be numbered and their approximate locations shown in the text. Each should be identified by placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for reproduction should be done in black (India) ink on pure white. Photographs should be on glossy paper and minimum of about 5 by 7 in. in size. A legend should be provided for each illustration and, preferably, attached to it.

All scientific material appearing in *The Journal* is reviewed by the Editorial Board. Manuscripts should be mailed to The Editor, West Virginia Medical Journal, Box 1031, Charleston, W. Va. 25324.

A message from . . .

The President

THE VOLUNTARY EFFORT — IT'S WORKING!

In January, 1978, the West Virginia State Medical Association and the West Virginia Hospital Association gave a joint liaison committee a new charge—to promote health care cost containment in cooperation with the American Medical Association, the American Hospital Association and the Federation of American Hospitals. Nationally, during the first six months of 1978, there was a 2.9-per cent decrease in the hospital inflation rate as compared to the first half of 1977.

This required a great deal of effort on the part of physicians and hospitals, and continued awareness of the attention that must be given to health care costs.

The real challenge, however, remains and is certain to be with us for a long time. That challenge calls for striking a delicate balance between cost on the one hand, and the availability of quality care on the other. I think physicians are equal to the challenge. Obviously, it will require some renewed and dedicated effort on our part, but there is no reason why we cannot make cost effectiveness our major current goal.

At this time in Washington, pressure continues to be exerted to bring about increased federal regulation of health care costs. This, of course, will not work, but it is obvious that it can be accomplished on a voluntary basis. Most of us realize that the general inflation rate in the country has been caused by, and maintained by, the excessive deficit spending and regulatory process of government.

As we approach another election, keep those thoughts in mind when you express your freedom at the ballot box or voting machine.

Robert D. Hess M.D.

Robert D. Hess, M. D., *President*

The West Virginia Medical Journal

Editorials

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author shall be held entirely responsible.

DEEPER MEANING

Election day is upon us in a political year dominated by the consequences of passage of Proposition 13 in California. In this political season, politicians have outdone one another in expressing fealty to the aims and ideas of all those supporters of tax reform excited into organized action by Proposition 13 success.

The specter of a taxpayer revolt perhaps obscures other important and deep-running feelings of resentment amongst long-suffering voters. We should recall that the year began with a mine workers' strike prolonged and made worse by inept political handling and a miscalculation of the miners' resolve to achieve a fair settlement.

The mine workers' stubborn resistance to a dictated settlement by anyone was a reflection of a more universal undercurrent of protest directed toward other forces molding, squeezing and shaping the lives of all of us in very undesirable ways.

There is a mood in the country of almost sullen resentment of plans and programs, as well as taxes; and of government people telling you what you must or you must not do. We are sick to death of being scolded about the "rights" of the poor and oppressed by do-gooding social planners. It is likely that the chief victims of any welfare cutback would be those who earn their living at administering and promoting welfare programs.

We cringe, hide and lock our doors as a result of judicial and penal programs of "rehabilitation" for those unfortunate victims of poverty, prejudice and social oppression who have turned to robbing and stealing and murdering to ease their frustration.

We are outraged at the degradation and outright failure of our educational system brought down by programmed educational gimmickery while we have been soft-soaped about the social values instilled in our illiterate graduates.

We understandably gnash our teeth and clutch aching stomachs at the sight of tax bills to pay for all this goodness.

Taxes are the tip of the iceberg we fear and resent. The use to which the taxes are put is a menace of greater consequence than the mere financial hurt we feel from the tax bite. Treasures beyond any money value are being taken from us by the use of those very tax dollars, only the collection of which we appear to protest.

Government long ago became intrusive in our personal lives. It is the intrusiveness that is now beyond endurance.

Medicine's concern in this issue, beyond the personal concerns of its individual members, is to block the avenues for intrusion now open and proposed to be opened by government involvement in medical care. There is nothing humans hold so sacredly private as matters pertaining to their bodies. Government's standard program involvement in any area, and particularly in medicine, introduces to an exponential degree opportunities for interference in citizens' lives.

To require anyone to pay through taxes for such an abominable breech into this, his most private area, is an affront not to be tolerated.

May we find a way in the coming year to make clear to our political friends (and enemies) that this year's wave of resentment at taxes has been generated by underlying more serious concerns about programs paid for by those taxes.

We wish you good judgment on election day.

SALUTE TO RESEARCH

The discussant for this month's Medical Grand Rounds appearing in *The Journal's* scientific section is Margaret J. Albrink, M. D., Professor of Medicine at West Virginia University. The Grand Rounds topic is "High-Density Lipoproteins: Possible Protective Factor Against Atherosclerosis."

It's highly appropriate, we believe, to note that Doctor Albrink has returned to her WVU duties in the past few weeks after a nine-month sabbatical at the Donner Laboratory for Medical Physics of the University of California, Berkeley,

where she continued her research on lips in the laboratory of Dr. Alex Nichols.

During her sabbatical, Doctor Albrink received the 1978 McCollum Award of the American Society for Clinical Nutrition, a $1,000 award presented at a special luncheon meeting of the Society in San Francisco. She also received a commemorative scroll citing her for having "uniquely combined basic investigations in nutrition with their application to clinical medicine, especially for meritorious research regarding the relationship of diet, plasma triglycerides and lipoproteins."

Doctor Albrink was recognized specifically for "the pioneering and central role her research has played in improving the understanding and treatment of a major type of hyperlipidemia and for elucidating important dietary aspects of this clinical malady." She is the 14th individual, and the first woman, to receive the McCollum Award, which honors Dr. Elmer V. McCollum for his role in establishing a foundation for the science of clinical nutrition.

A member of the WVU faculty since 1961, Doctor Albrink has had a notable career in teaching and research—particularly in the field of metabolic disease and lipid metabolism. She also has served as a consultant to the National Institutes of Health's metabolic study section; the National Heart, Lung and Blood Institute; the Federal Trade Commission, and the Food and Drug Administration.

It's a pleasure for *The Journal* likewise to salute Doctor Albrink—and her thousands of colleagues who devote countless hours to the study, research and experimentation that represent such a vital component of the high quality of health and medical care the citizens of this nation enjoy.

REPRESENTATION

What is the price of representation of our profession in the ongoing debate on the way medicine is practiced, financed and administered across our land?

The price of that representation is the $250 membership dues to the American Medical Association (considerably less for physicians in their first year of practice, residents, and students).

And leaders of many state and county medical societies have been pounding this home.

Noting the cost of the "many AMA activities and services," Guy T. Selander, M. D., wrote last year when President of the Duval County Medical Society, Jacksonville, Florida:

"It is the individual doctor's responsibility to carry his/her share of the economic load."

As for complaints that the dues are too high, he said, "Annual dues at most of the Jacksonville area country clubs, all of which have large doctor representation, are higher than membership in the American Medical Association."

Eyeing the Washington scene, George H. Dietz, M. D., wrote in April as President of the Mahoning County Medical Society, Youngstown, Ohio:

"Without doubt, the American Medical Association is a potent force in the political arena, working for the good of the patient and the doctor alike. I am amazed at its effectiveness . . . I am convinced that if there were no AMA, some sort of total-care government (federal) program would now long since have been a reality."

In a similar vein, John J. Egan, M. D., President of the Medical Society of Delaware, has observed that his society and the AMA "are unifying forces whose role is to blend the viewpoints of all physicians into concerted and effective action. The strength of organized medicine derives entirely from the participation and support of individual physicians."

Likewise calling for unity, John F. Kahle, M. D., immediate Past President of the Arizona Medical Association, has bemoaned those physicians whose response to today's challenges consists of "withdrawing into their own shells, rather than joining or encouraging the fight against the real enemy—governmental intrusion."

These (and numerous other medical society articles we could quote) make it plain that joining the AMA isn't just hopping into a caravan. It's an emergency vehicle that's involved, and the very future of medicine is on the litter.

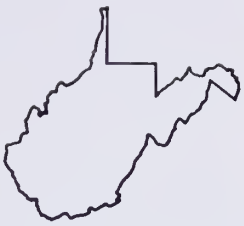
That's an important warning to sound to any nonmember physicians you know.—*Guest Editorial by American Medical Association.*

EARLY WARNING

By now, physicians should have a general idea of the restyled, 1978 version of labor's national health insurance program being pushed by Sen. Edward Kennedy (D-Mass.). If not, they should take immediate steps to become informed. We'll have more to say later.

Rigid controls would dominate the federally-run program, including mandatory fee schedules for physicians and negotiated hospital budgets. Basically, the Kennedy plan calls for a tightly regulated public utility structure for health care —with, of course, favorable treatment for labor by carefully exempting non-supervisory hospital employes from any of the burdensome aspects of the program.

GENERAL NEWS



Boston, Houston, WVU Speakers On Conference Program

Additions to the program for the 12th Mid-Winter Clinical Conference to be held in Charleston next January 26-28 will include talks on fee-for-service HMOs, coronary artery medicine and surgery, and anemia in cancer, it was announced by the Program Committee.

Dr. Richard H. Egdahl, Director of the Boston University Health Policy Institute, will speak on "A Progress Report on Fee-for-Service HMOs" during the physicians' session Friday evening, January 26, while Dr. John C. Norman of Houston, Texas, will discuss "Coronary Artery Medicine and Surgery: Concept and Controversy" at the Saturday afternoon session. Dr. Peter C. Raich, Professor of Medicine and Chairman, Division of Hematology/Oncology at the West Virginia University Medical Center in Morgantown, will speak on "The Anemia of Cancer" during the concluding conference session Sunday morning.

Richard H. Egdahl, M. D.

The conference, to be held at the Holiday Inn Charleston House, will begin Friday afternoon, January 26. The annual continuing education event is sponsored by the State Medical Association and the West Virginia and Marshall University Schools of Medicine.

Scientific sessions for physicians will be held Friday afternoon, Saturday morning and afternoon, and Sunday morning.

As announced previously, the sessions will be held on the topics of "Physical Fitness, Obesity and Diet Therapy" (Friday Afternoon), "Current Practices in Immunization" (Saturday Morning), "Coronary Artery Disease" (Saturday Afternoon), and "Current Concepts in Hematology" (Sunday Morning).

The conference schedule also will include, as announced previously, a Friday evening public session developed from the Friday afternoon physicians' session on "Physical Fitness, Obesity and Diet Therapy," and a dinner program Saturday evening.

Former Chairman of Surgery

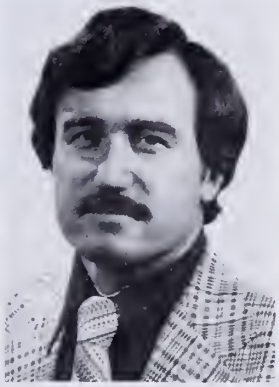
Doctor Egdahl, a surgeon, also is Academic Vice President for Health Affairs at Boston University, Executive Vice President of the University's Hospital, and Director of the University's Medical Center. He has held these positions since 1973, having previously served as Professor and Chairman of the University's Department of Surgery since 1964.

Certified by the American Board of Surgery (1959), he is a member of the editorial boards of the American Journal of Surgery, Surgery, and Health Care Management Review. He was President of the Society of University Surgeons in 1971 and President of the Boston Surgical Society in 1976-77.

Among a number of committee and other appointments, Doctor Egdahl has served as Consultant to the Director, National Center for Health Services (Health Care Technology Productivity) (1971-72), and Senior Health Consultant, President's Advisor Council on Management Improvement (1971-73).

A native of Eau Claire, Wisconsin, Doctor Egdahl was graduated from Dartmouth College and received his M. D. degree in 1950 from Har-

John C. Norman, M. D.



Peter C. Raich, M. D.

vard Medical School. He also holds a Ph.D. degree from the University of Minnesota (1957). He was Professor of Surgery and Director of the Research Laboratory at the Medical College of Virginia from 1957 to 1964.

Native of Charleston

Doctor Norman, a native of Charleston, is a cardiovascular surgeon at the Texas Heart Institute in Houston, and also is Director of the Institute's Cardiovascular Surgical Research Laboratories and Editor of Cardiovascular Diseases, bulletin of the Institute.

Certified by the American Board of Surgery and the American Board of Thoracic Surgery, he is a Fellow of the American College of Cardiology and the American College of Surgeons, and a member of various other societies, including The Transplantation Society and the American Surgical Association.

Doctor Norman was graduated from Harvard College and received his M. D. degree in 1954 from Harvard Medical School. He interned and served residencies at Columbia-Presbyterian Medical Center and Bellevue Hospital in New York City. He also was a thoracic and cardiovascular Fellow in 1962-63 at the University of Birmingham (England), and a thoracic and cardiovascular resident at the University of Michigan Medical Center in 1963-64.

Doctor Norman, Clinical Professor of Surgery (cardiothoracic) at the University of Texas Health Sciences Center, was Consultant for The President's Ad Hoc Panel on Heart Diseases in 1972-73.

He previously held teaching posts at Harvard and since has lectured there and been Visiting Professor at Wayne State University, Dalhousie University, Halifax, Nova Scotia, the University of Miami (Florida), and WVU (1976).

Doctor Norman is a Fellow of the Council on Cardiovascular Surgery, American Heart Association, and is the author or co-author of some 530 scientific articles and abstracts.

University of Wisconsin

Doctor Raich joined the WVU School of Medicine faculty last July, coming from Madison, Wisconsin, where he had held teaching and clinical faculty appointments at the University of Wisconsin's Medical School and Center for Health Sciences.

He is certified by the American Board of Internal Medicine and the American Board of Hematology, and is a Fellow of the American College of Physicians (1977). He is a member of the Polycythemia Vera Study Group and the Cancer and Acute Leukemia Group B (CALGB) Study Group, and was a member and Chairman of Lymphoma Studies, Wisconsin Hematology Study Group (1970-76), and member of the Eastern Cooperative Oncology Group (ECOG), Hematology Steering Committee and Lymphoma Subcommittee (1976-78).

Doctor Raich is a manuscript reviewer for Cancer and Journal of Laboratory and Clinical Medicine, and was abstracter for Excerpta Medica, Hematology Section, from 1974 to 1978.

He was graduated from the University of Wisconsin and received his M. D. degree in 1964 from that institution's Medical School. He interned at Chicago Wesley Memorial Hospital and was a Staff Associate, United States Public Health Service, National Institutes of Health, in Bethesda, Maryland, from 1965 to 1967. He was a resident in internal medicine and Fellow in hematology from 1967 to 1971 at the University of Wisconsin Center for Health Sciences.

Doctor Raich is the author or co-author of some 25 scientific articles and abstracts.

Other Program Information

Previously announced speakers and their topics include:

Friday Afternoon: "Overuse Syndromes in the Recreational Athlete,"—Fred L. Allman, Jr., M. D., The Sports Medicine Clinic, Atlanta; "Our Overgrown Children"—Ruth C. Harris, M. D., Professor and Chairman of Pediatrics, Marshall University School of Medicine, and "Management of Cholesterol and Triglycerides"—Frederick J. Stare, M. D., Professor of Nutrition, Harvard University School of Public Health;

Saturday Morning: "Influenza Virus Vaccines"—Ronica M. Kluge, M. D., Associate Professor of Medicine and Chairman, Division of Infectious Diseases, WVU School of Medicine, and

Sunday Morning: "Current Use of Blood Products"—Mabel M. Stevenson, M. D., Medical Director, Tri-State Red Cross Blood Center, Huntington.

The program meets the criteria for 12 credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association, and is expected to carry prescribed credit by the American Academy of Family Physicians.

Serving on the Program Committee are Drs. Ralph H. Nestmann and Joseph T. Skaggs, both of Charleston, Co-Chairmen, and Drs. William O.

McMillan, Jr., Charleston; Maurice A. Mufson, Huntington; Robert L. Smith, Morgantown, and C. Carl Tully, South Charleston.

Additional details, including other conference speakers, will be provided in later issues of *The Journal* as the program is completed.

Help of Physicians Sought In Immunization Push

Many West Virginia physicians will be asked for information about immunizations during the next few months, George E. Pickett, M. D., M. P. H., the State's Health Director, has explained.

Declining immunization levels across the United States have prompted a national effort to identify and immunize an estimated 20 million susceptible children under age 15. The program, called the National Immunization Initiative, was begun in April, 1977.

The major goals of the campaign are to raise immunization levels to over 90 per cent by October, 1979; and to provide comprehensive immunization services to the three million children born each year in the United States.

As a part of this national effort, Doctor Pickett has emphasized, school systems across West Virginia began in mid-October to screen immunization records of all currently enrolled children. The strict enforcement of the State's compulsory immunization law now guarantees completed immunizations among children entering kindergarten and first grade.

"However," Doctor Pickett has said, "those who entered school several years ago when enforcement may not have been effective—or when less potent immunizing agents or schedules were in use—may not be adequately protected, leaving immunization levels lows enough to allow disease outbreaks in the school setting."

The epidemic of measles which occurred in West Virginia this past spring clearly demonstrated, the Health Director believes, that outbreaks will occur if sufficient numbers of children are inadequately immunized. Early samples show that only 65 per cent of children may be adequately immunized in some schools.

A more complete record review, to be conducted by school officials in cooperation with local health departments, will identify children in grades two through 12 who are in need of measles vaccine or measles re-immunization. In grades two through eight, records will also be screened for the need for rubella vaccine, as well as polio and diphtheria-tetanus booster doses.

Parents are being notified if records are incomplete, and have been asked to provide proof of adequate immunization by November 1. The program includes awareness activities to educate parents to the dangers of childhood diseases and the importance of complete protection, as well as provision for expanded immunization services by county health departments.

Temporary rules have been promulgated which may allow the State Health Director to bar any child from entering school without proof of adequate immunization if the level in that school is below 90 per cent. Parents will have to obtain evidence of adequate immunization or have their children immunized. Many will call on their family physicians for information and assistance. Wherever possible, nurses will be available in the schools to provide immunizations.

"The protective barrier against needless and pernicious diseases has slipped. We need to rebuild it which will take an extra effort and an extra measure of patience during October, November and December. Once repaired, we must keep the barrier in place," Doctor Pickett has stressed.

Eastern Panhandle apples at break time have become a tradition at the annual Hal Wanger Family Practice Conference held in September at West Virginia University Medical Center. Getting ready to enjoy theirs are (from left) Drs. H. Alexander Wanger of Martinsburg and Dr. William H. Wanger of Beckley, sons of the physician for whom the conference is named, and John W. Traubert, Professor and Chairman of the sponsoring Department of Family Practice at WVU School of Medicine.

Review A Book

The following books have been received by the Headquarters Office of the State Medical Association. Medical readers interested in reviewing any of these volumes should address their requests to Editor, *The West Virginia Medical Journal,* Post Office Box 1031, Charleston 25324. We shall be happy to send the books to you, and you may keep them for your personal libraries after submitting to *The Journal* a review for publication.

Current Obstetric & Gynecologic Diagnosis and Treatment, 2nd Edition, by Ralph C. Benson, M.D. 976 pages. Price $18. Lange Medical Publications, Los Altos, California 94022. 1978.

Review of Medical Pharmacology, 6th Edition, by Frederick H. Meyers, M. D.; Ernest Jawetz, M. D., Ph. D.; and Alan Goldfien, M. D. 762 pages. Price $14.50. Lange Medical Publications, Los Altos, California 94022. 1978.

Everything You Always Wanted to Know About Nutrition, by David Reuben, M. D. 287 pages. Price $9.95. Simon and Schuster, New York, New York 10020. 1978.

The Metabolic Management of the Critically Ill, by Douglas W. Wilmore, M. D. 262 pages. Price $22.50. Plenum Publishing Company, New York, New York 10011. 1977.

General Urology, 9th Edition, by Donald R. Smith, M. D. 541 pages. Price $14.50. Lange Medical Publications, Los Altos, California 94022. 1978.

Charleston Diabetes Conference Scheduled November 17

A conference, "Clinical Update in the Management of Diabetes," will be held on November 17 in the Education Building of the Charleston Division, West Virginia University Medical Center.

Sponsors are the Charleston Diabetes Association and the Charleston Division/WVU.

The program is designed for the physician, nurse, pharmacist, dietitian and other health professionals who work with diabetics or who are interested in diabetes. Any interested person may attend.

The program will begin at 8:15 A. M. following registration at 7:30 and opening remarks at 8 o'clock by Stephen R. Grubb, M. D., Assistant Professor of Medicine, Charleston Division/WVU.

The speakers and their topics will include:

"Use and Abuse of Insulin"—Thomas G. Skillman, M. D., Kurtz Professor of Endocrinology, Department of Medicine, Ohio State University, Columbus; "Coma in the Diabetic"—Jerome M. Feldman, M. D., Associate Professor of Medicine, Duke University Medical Center, Durham, North Carolina; "Diabetes in the Complicated Patient: The Surgical and Obstetrical Diabetic"—Stephen A. Artz, M. D., Clinical Associate Professor of Medicine, Charleston Division/WVU;

"Lipids and Vascular Disease"—Margaret J. Albrink, M. D., Professor of Medicine, WVU,

Shown above are some of the state medical society presidents and their wives who attended the 111th Annual Meeting of the West Virginia State Medical Association August 23-26 at the Greenbrier in White Sulphur Springs. In the left photo, from left, are Doctor and Mrs. Francis C. Mayle, Jr., Maryland, and Dr. and Mrs. Harvey H. Ammerman, District of Columbia. Dr. and Mrs. William J. Hagood, Jr., Virginia, are shown in the right photo.

Morgantown; "New Developments in Diabetes" —Doctor Skillman; "Role of Oral Hypoglycemics"—Doctor Feldman;

"Diabetes in Childhood"—William G. Klingberg, M. D., Professor and Chairman, Department of Pediatrics, WVU, Morgantown, and "Insulin Resistance"—Douglas L. Jones, M. D., Assistant Professor of Medicine, Charleston Division/WVU.

The scientific presentations will be followed by workshops beginning at 4 P. M. for physicians, nurses, pharmacists and dietitians, and a diabetic dinner at 5 P. M.

Charleston physicians participating in the physicians' workshop will be Drs. Donald E. Farmer, Stephen K. Milroy, Nolan C. Parsons and Robert B. Point (Dermopathy); George E. Toma and Robert E. O'Connor (Ophthalmology), and Marshall J. Carper and Douglas L. Jones (Neuropathy). Conducting a workshop in Podiatry will be G. M. Arnold, P. D., of South Charleston.

The dietetic dinner will offer a firsthand view of the actual caloric implications of the foods available and the implications of the foods selected for the diabetic.

The fee for physicians will be $25, with an additional late fee of $5 for registrations after November 10. The charge for the diabetic dinner is $5.

The program meets the criteria for six hours of credit in Category 1 of the Physician's Recognition Award of the American Medical Association; and has been approved by the American Diebetic Association for six hours of continuing education credit. Additionally, the course has been approved for .7 CEUs.

For additional information contact the Department of Continuing/Consumer Education, Charleston Division/WVU; phone (304) 345-2600, ext. 242/244.

'Medical Rehabilitation' Subject For December 8 Meeting

A conference on "Medical Rehabilitation and Facility Needs in West Virginia: What Direction?" is scheduled for Friday, December 8, in the auditorium of the West Virginia University Medical Center's Charleston Division, 3110 MacCorkle Avenue SE.

The conference will be an outgrowth, in large measure, of work done by the West Virginia State Medical Association's Medical Economics Subcommittee on Vocational Rehabilitation; and a 1977 resolution adopted by the Association's House of Delegates calling for documentation of the need for a Physical Rehabilitation Center in the state.

As a result of the resolution, the Association Committee coordinated its efforts with that of the WVU Medical Center's Department of Community Medicine to make the first detailed study of medical rehabilitation facility and service needs in West Virginia beyond those for the potentially employable at the Vocational Rehabilitation Center in Institute.

Principal findings of that study, engineered by Judith Greenwood, Ph. D., Research Associate for the WVU Department of Community Medicine at the Medical Center's Charleston Division, will be cornerstone for the December 8 conference.

Such topics as an overview of economic, health and personal consequences of unmet rehabilitation needs; consequences to individuals if appropriate and timely rehabilitation is not available; how other states have addressed the problem, and advantages and disadvantages of various alternatives for meeting medical rehabilitation needs will be explored during the 10 A.M.-4:30 P.M. discussions.

Dr. R. John C. Pearson, Chairman of WVU's Department of Community Medicine, and Dr. Robert L. Ghiz of Charleston, Chairman of the Medical Association's Medical Economics Committee as well as the Subcommittee on Vocational Rehabilitation, will be among those playing leading conference roles.

Dr. Robert W. Coon, Dean of the Marshall University School of Medicine, will preside at a summation of materials and ideas offered during the day; with State Senate President William T. Brotherton, Jr. (D-Kanawha) among others from West Virginia and other states who will have important parts in the program.

Additional information regarding the conference may be obtained from Judith Greenwood, Ph. D., Research Associate, Department of Community Medicine, WVU Medical Center Charleston Division, 3110 MacCorkle Avenue SE, Charleston 25304; telephone 345-2600, extension 382.

Continuing Education Activities

Here are the continuing medical education activities listed primarily by the West Virginia University School of Medicine for part of 1978 and 1979, as compiled by Dr. Robert L. Smith, Assistant Dean for Continuing Education. The schedule is presented as a convenience for physicians in planning their continuing education program. (Other national, state and district medical meetings are listed in the *Medical Meetings* Department of The Journal.)

The program is tentative and subject to change. It should be noted that weekly conferences also are held on the Charleston and Wheeling campuses as well as in Morgantown. Further information about these may be obtained from: Division of Continuing Education, WVU Medical Center, 3110 MacCorkle Avenue, S.E., Charleston 25304; Office of Continuing Medical Education, WVU Medical Center, Morgantown 26506; or, Office of Continuing Medical Education, Wheeling Division, WVU School of Medicine, Ohio Valley Medical Center, 2000 Eoff Street, Wheeling 26003.

Nov. 3, 4	Morgantown	Neuroscience Teaching Day
Nov. 3, 4	Morgantown	Cardiology Teaching Days
Nov. 9	Wheeling	Family Practice Seminar
Nov. 17, 18	Morgantown	Emergency Medicine Seminar
Dec. 6	Morgantown	Infant Nutrition
April 6, 7	Morgantown	Cancer Teaching Days

Visiting Professors In Ob-Gyn And Surgery At WVU

Below is the schedule of Visiting Professor lectures (November through spring of 1979) for the Department of Obstetrics and Gynecology and the Department of Surgery of the West Virginia University Medical Center in Morgantown.

The Obstetrics and Gynecology Visiting Professor will participate in Departmental Grand Rounds at 2 P. M. on Thursday. The scheduled presentations (below) will be given at 4 P. M. Thursday and 7:30 A. M. Friday. No registration fee is charged for this series.

"The Induction of Ovulation and "Modern Approaches to Tubal Surgery"—Melvin L. Taymor, M. D., Associate Clinical Professor, Obstetrics and Gynecology, Harvard Medical School, November 16-17; "Germ Cell Tumors of the Ovary" and "Hyperplasia and Adenocarcinoma Fundus Uteri"—J. Donald Woodruff, M. D., Richard W. TeLinde Professor of Gynecologic Pathology, Johns Hopkins University School of Medicine, December 7-8;

"Continuing Education — the Physician Renaissance or Rip-Off?" and "White Man's Medicine — in Red Man's Country" — Richard W. Stander, M. D., Director of Education, American College of Obstetricians and Gynecologists, April 12-13; "Prenatal Detection of Inherited Disorders" and "Primary Amenorrhea, Gonadal Dysgenesis" — Gloria E. Sarto, M. D., Professor and Vice Chairperson, Northwestern University School of Medicine, Chicago, May 3-4, and "Antenatal Fetal Assessment—Electronic Monitoring of the Fetus and Fetal Brain" and "Medicine and Anesthesia in Pregnancy: A Clinician's Guide"—Mortimer G. Rosen, M. D., Professor of Obstetrics and Gynecology, Case Western Reserve University School of Medicine, Cleveland, June 7-8.

Surgery

Visiting Professors in Surgery will lecture at 8 A. M. on Friday and 9 A. M. on Saturday. No fees are charged in this series.

"Diabetic Foot"—James P. Boland, M. D., Professor and Chairman, Department of Surgery, Charleston Division, WVU, November 3-4; "Transplantation Using ATG" and "Vascular Access"—Khalid Butt, M. D., Associate Professor, Department of Surgery, Brooklyn Downstate University, December 1-2;

"The Metabolic Response to Injury in the Healing Wound" and "Metabolic Management of the Critically Ill"—Douglas W. Wilmore, M. D., Chief, Clinical Investigation, Department of Army, Brooke Army Medical Center, January 19-20, and "Chemotherapy for Surgeons" and "Occult Leading from the GI Tract"—J. Bradley Aust, M. D. Professor and Chairman, Department of Surgery, University of Texas, San Antonio, March 16-17.

Winter Scientific and Business Programs Set By AMA

The 32nd winter scientific meeting of the American Medical Association will be held December 7-10 in Las Vegas at the Las Vegas Convention Center.

Meanwhile, the AMA's interim business session, including meetings of its House of Delegates

Frank J. Holroyd, M. D.

Richard E. Flood, M. D.

and other councils and committees, is scheduled for December 3-6 at the Palmer House in Chicago. West Virginia's Delegates in the House are Drs. Frank J. Holroyd of Princeton and Richard E. Flood of Weirton, with Drs. Harry S. Weeks, Jr., of Wheeling and Jack Leckie of Huntington as Alternate Delegates. Doctor Holroyd has an assignment on one of the Reference Committees which will consider resolutions introduced into the House and report their recommendations to the floor.

The scientific meeting is held each winter to provide American physicians with a broad-based learning experience in new developments in medical care.

In addition to more than 50 continuing education courses in all aspects of medical care, there will be state-of-the-arts lectures in selected medical areas, other lectureships, teaching luncheons, scientific exhibits, videoclinics, motion pictures, telecourses and teaching by videodisc.

The scientific program for the meeting was published in the October 13 Journal of the American Medical Association.

National medical societies will for the first time provide programs under their own sponsorship as a part of the winter meeting. Specialty programs will be provided by the American College of Chest Physicians, American College of Physicians, American Society for Clinical Pharmacology and Therapeutics, and the Section Council on Plastic and Reconstructive Surgery.

Kirk V. Cammack, M. D., of Las Vegas is Program Chairman for the meeting, with Owen C. Peck, M. D., of Reno as Co-Chairman. The meeting is under the direction of the AMA's Council on Continuing Physician Education, with John E. Albers, M. D., of Cincinnati as Chairman and James L. Breeling of Chicago as Secretary.

AMA leaders will offer a report to the membership on problems facing American medicine and what the AMA is doing about them at a special program on Friday, December 8. Speakers will be Robert B. Hunter, M. D., of Sedro Woolley, Washington, Chairman of the AMA

Dr. John J. Gaughan of Cleveland, President of the Ohio State Medical Association, and Mrs. Gaughan (left photo) are shown at a reception during the State Medical Association's Annual Meeting in August at the Greenbrier. On the right (center) are Dr. and Mrs. William Y. Rial of Swarthmore, Pennsylvania. Doctor Rial is Speaker of the House of Delegates of the American Medical Association. With them are Dr. Frank J. Holroyd (left) of Princeton, a State Medical Association Delegate to the AMA, and Dr. Stephen D. Ward, Wheeling, President Elect of the Association.

Board of Trustees; Tom E. Nesbitt, M. D., of Nashville, Tennessee, AMA's President and James H. Sammons, M. D., Chicago, AMA Executive Vice President.

Linas Pauling To Lecture

Linas Pauling, world-renowned chemist who has been awarded two Nobel Prizes, for chemistry in 1954 and the Peace Prize in 1962, will present a special lecture on his often controversial theory of the use of massive doses of vitamin C for the common cold and other health problems.

Some topics new to the AMA scientific programs will be included in the Las Vegas meeting.

Particularly suitable to the convention site will be a three-hour program on "Treatment of the Compulsive Gambler," with Robert L. Custer, M. D., of Washington, D. C., as moderator. The speakers will discuss the behavioral aspects of compulsive gamblers so that physicians will have a guide to assist in identification of the person in need of treatment. Techniques of treatment will be described.

A subject often in the news this year is the escalating costs of health care. A special program will be presented, stressing the physician's responsibility in ensuring provision of cost-effective health care. New practice patterns that will reduce costs will be suggested, including judicious use of auxiliary and supportive services, and evaluation of the scientific validity of specific diagnostic and therapeutic techniques in relation to cost.

The term "holistic medicine" has been used to cover a variety of newer or alternative approaches and viewpoints on health. A session will be devoted to this subject, to inform doctors on what holistic medicine proposes, and an evaluation of how useful it is.

Terrorist Behavior

The psychiatric behavior of both the terrorist and the victim will be illustrated by specific terrorism incidents in a special program on the medical and psychiatric aspects of international terrorism and rescue. This symposium will discuss the political background, frequency of terrorism, and special weapons and wounds incurred. A successful mode of staged medical care devised specifically for these situations will be described.

While hypochondriacs have a need to hold on to their symptoms, doctors have a need to cure, and a portion of the program will be devoted to the tug-of-war between physicians and those with imaginary ailments in the health care picture. Texas psychiatrist Robert R. Rynearson, M. D., of Temple will be moderator.

One of the continuing education courses, yet to be selected, will be broadcast from the meeting via a communciation satellite to some 30 Veterans Administration hospitals in the western states.

The AMA Auxiliary will conduct its convention in conjunction with the winter scientific meeting.

Auxiliary Honors Mrs. Jarrett For 50-Year History

Mrs. Joe N. Jarrett of Oak Hill was unanimously elected to honorary life membership in the Auxiliary to the West Virginia State Medical Association during the annual meeting of the Auxiliary in August at the Greenbrier in White Sulphur Springs.

Mrs. Joe N. Jarrett

Mrs. Jarrett, a Past President of the State Auxiliary, was honored for her years of work in writing *Half A Century*, a 50-year history of the Auxiliary in West Virginia.

The resolution honoring Mrs. Jarrett originated through her local auxiliary, the Auxiliary to the Fayette County Medical Society.

A resolution adopted during the 1977 Annual Meeting of the State Medical Association also cited Mrs. Jarrett for her work on the history.

'Alarming' Risk In Pill, Smoking Combination Reaffirmed

Food and Drugs Commissioner Donald Kennedy recently said that three new studies confirm that cigarette smoking greatly enhances the risk of heart attacks, strokes and other circulatory disorders in women using birth control pills.

Since April, 1978, the FDA has required that labeling of birth control pills warn women and physicians that women who smoke should not use birth control pills. The warning was based on two earlier studies that were completed from 1975-1977.

In testimony before the House Subcommittee on Intergovernmental Relations and Human Resources, Doctor Kennedy reported on the three new studies:

The Kaiser-Permanente Contraceptive Drug Study. Walnut Creek, California, found that women who used birth control pills and smoked were 22 times as likely to suffer from certain kinds of strokes as those who neither smoked nor used the pill.

The Boston Collaborative Drug Surveillance Program found that in women between the ages of 37 and 46 who take birth control pills the risk of heart attack is 14 times higher than in women in the same age group who do not take them. Of these pill users who suffered a heart attack, 92 per cent were smokers.

Tentative results of a study supported by the FDA and the National Institutes of Health at the Boston Drug Epidemiology Unit strongly reaffirm that smoking greatly enhances the risk for circulatory disorders in birth control pill users, Doctor Kennedy told the subcommittee. The data from this study will be published in the future.

Five Studies Agree

"The very firm association between oral contraceptive use and smoking in enhancing cardiovascular risks has now been established beyond a reasonable doubt. No less than five independent studies agree on the association, and show risk elevations for the combination that are truly alarming," Doctor Kennedy said.

"I would be astonished, frankly, if anyone who understands the scientific basis for establishing the presumption of risk would challenge the conclusion that the lethality of cigarettes is amplified in women who also use oral contraceptives."

In explaining the justification for requiring the warning in birth control pill labeling. Doctor Kennedy said:

"Because patients have asked for more information on risks associated with oral contraceptive use and because we believe that physicians should have the latest available information on which to decide whether to prescribe oral contraceptives for individual patients, we have included in the labeling a strong warning against smoking by oral contraceptive users.

"Labeling information allows consumers to participate in basic decisions affecting their personal health and safety—in this case, to decide for themselves whether they would rather take oral contraceptives and not smoke, or smoke and use other methods of contraception."

The FDA requires that each time a prescription for the pill is filled, women receive a detailed brochure and a summarized leaflet explaining the benefits and risks of birth control pills.

The boxed warning, which appears in both the brochure and leaflet, says: "Cigarette smoking increases the risk of serious adverse effects on the heart and blood vessels from oral contraceptive use. This risk increases with age and with heavy smoking (15 or more cigarettes per day) and is quite marked in women over 35 years of age. Women who use oral contraceptives should not smoke." The same warning appears in labeling for physicians.

Average Newborn Intensive Care Cost $115,356

The average cost of insuring that a premature infant will leave the hospital healthy and "normal" is $115,356,* according to a report in a recent issue of Pediatrics, the monthly scientific journal of the American Academy of Pediatrics.

In a study involving 75 infants who weighed 2.2 lbs. or less at birth, a team of researchers from Cedars-Sinai Medical Center and the University of California at Los Angeles computed the in-hospital "cost of living" for premature infants who did not survive, for those who survived but had developmental or neurological problems, and for those who survived and were considered normal.

A breakdown of the total charges included: room charges, 43 per cent; ventilator and oxygen support, 19 per cent; blood gases, 11 per cent; pharmacy, 9 per cent; laboratory, 8 per cent; central supply, 5 per cent; radiology, 4 per cent; and miscellaneous, 1 per cent. Physicians' fees represented less than 5 per cent of the total bill and were not included.

The average daily cost for the 45 infants who died within one to 165 days was $825 per infant. Total charges ranged from $72 to $124,624. The average total cost per nonsurvivor was $14,236.

Due to less time spent in the intensive care unit, the average daily cost for surviving infants was less than for nonsurvivors. The approximate cost was $450 per day, for an average stay of 89 days. Total charges per survivor ranged from $10,744 to $106.050, with the average total equalling $61,641.

70 Per Cent Normal in Follow-Up

In follow-up developmental/neurological testing at 12 months to 3 years, 70 per cent of the surviving infants were functioning normally. The

*This figure was updated as of November, 1977. In accordance, the other figures have risen 31 per cent since September, 1976.

total cost in these cases, as mentioned, was $115,356 per infant.

The total adjusted cost for the 45 nonsurviving infants was $640,634. The total adjusted cost for the 30 surviving infants was $1,208,582. The grand total for both groups was $1,849,216.

Whereas 15 years ago, the report noted, infants weighing 2.2 lbs. or less had a 10 per cent survival rate, wtih survivors usually suffering mental or physical handicaps, the development of new equipment and new procedures in perinatal medicine has allowed even the smallest of babies to survive and have a better chance of leading a normal life.

Is it worth the price? This team of researchers believed the cost was justifiable. They pointed out, however, that society, which bears the cost as well as the consequences, must make the final judgment.

Authors of the report are: Jeffrey J. Pomerance, M. D., M. P. H.; Christina T. Ukrainski, M. D.; Tara Ukra, Diane H. Henderson, M. D.; Andrea H. Nash, M. D., and Janet L. Meredith, R. N., B. S.

AMA Issues Allied Health Education Directory

The Seventh Edition of the American Medical Association's Allied Health Education Directory is now off the press, with listings of 2,834 educational programs for 23 allied health occupations.

Program listings present information on tuition costs, prerequisites for admission, length of program, and degrees awarded. A section on financial aid is also included.

A detailed description of each of the following occupations appears: Physician's assistant, cytotechnologist, electroencephalographic technician, electroencephalographic technologist, histologic technician, medical assistant, medical assistant in pediatrics, medical laboratory technician (associate degree), medical laboratory technician (certificate), medical record administrator, medical record technician, medical technologist, nuclear medicine technologist, occupational therapist, operating room technician, ophthalmic medical assistant, physical therapist, radiation therapy technologist, radiologic technologist, respiratory therapist, respiratory therapy technician, and specialist in blood bank technology.

Individual copies are available from the AMA Order Department OP-393, P. O. Box 821, Monroe, Wisconsin 53566 for $10.

Medical Meetings

Nov. 2—Dept. of Pediatrics, CAMC (Guest Lecture Series), Charleston.

Nov. 2-5—Med. Society of Virginia, Williamsburg.

Nov. 10-12—Achievement Center of Roanoke (Va.), Children's Learning Disabilities Conference, White Sulphur Springs.

Nov. 11-14—Southern Medical Assn., Atlanta.

Nov. 17—Charleston Diabetes Assn., Charleston Division, WVU (Management of Diabetes), Charleston.

Nov. 29—Am. Diabetes Assn., Chicago.

Dec. 1-4—Cystic Fibrosis Foundation, Atlanta.

Dec. 2-6—AMA Delegates Winter Meeting, Chicago.

Dec. 2-7—Am. Academy of Dermatology.

Dec. 7-10—AMA Winter Scientific Session, Las Vegas.

Dec. 8—Med. Rehabilitation Conference, Charleston.

1979

Jan. 4—Dept. of Pediatrics, CAMC (Guest Lecture Series), Charleston.

Jan. 15-18—Dept. of Anatomy, MCV (Alton D. Brashear PG Course in Head & Neck Anatomy), Richmond.

Jan. 26-28—12th Mid-Winter Clinical Conference, Charleston.

Jan. 27-31—Am. College of Allergists, San Francisco.

Feb. 23-24—Va. Chap., Am. Academy of Pediatrics, Williamsburg.

March 1—Dept. of Pediatrics, CAMC (Guest Lecture Series), Charleston.

March 7-9—Nurses Assn. of Am. College of Obstetricians & Gynecologists, Chicago.

March 11-15—Am. College of Cardiol., Miami Beach.

March 22-29—Am. Society of Clinical Pathologists, New Orleans.

March 30-April 1—W. Va. Chap., AAFP, Charleston.

March 31-April 1—Am. Otology Society, Los Angeles.

April 2-5—ACS, Denver.

April 22-25—W. Va. Academy of Ophthalmol. & Otolaryngol., White Sulphur Springs.

April 23-28—Am. Academy of Neurology, Chicago.

May 24—Dept. of Pediatrics, CAMC (Guest Lecture Series), Charleston.

July 21-26—AMA Delegates Summer Meeting, Chicago.

Aug. 22-25—112th Annual Meeting, W. Va. State Medical Assn., White Sulphur Springs.

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WVU Medical Center
–News–

Compiled from material furnished by Mrs. Mary Ellin Wylie, Director, Medical Center News and Information Services, Morgantown, W. Va.

Diagnoses, Help, Research MD Clinic Functions

Because they share a prominent characteristic, progressive degeneration of the skeletal or voluntary muscles, a large group of chronic and for the most part hereditary diseases also share a general designation—muscular dystrophy.

Information and help are what patients and their families seek when they come to West Virginia University Hospital's Muscular Dystrophy (MD) Clinic.

Many of the patients are young, and most have difficulty walking.

For some, such as the four-year-old boy found to have Duchenne dystrophy, the verdict is heavy —no cure is known, not even treatment that might slow deterioration of the muscles.

For other patients, such as the 10-year-old girl whose tests show her muscle weakness comes from chronic polymyositis, the news is less burdensome—with steroid therapy she'll regain her strength and her ability to walk normally.

In addition to a definitive diagnosis, however, what these and other patients find in this clinic staffed mainly by members of the WVU School of Medicine's Department of Neurology is practical help in large measure.

Part of that help results because this special clinic was established last year (1977) in conjunction with the Muscular Dystrophy Association (MDA). Another clinic, with services provided by WVU clinical faculty members, is located at Charleston Area Medical Center.

Patients with a tentative diagnosis from their doctors are referred for studies and evaluation. Not only does the MDA pay for complete examinations for differential diagnosis at these clinics, but it will finance other specific follow-up care when clinic physicians determine patients have one of the many kinds of neuromuscular disorders covered by the Association's program.

The list of authorized services is long: wheelchairs, walkers, braces, crutches, canes and other orthopedic appliances; equipped hospital beds, hydraulic lifts, assorted aids for daily activities, such as special eating utensils; physical therapy which, while it cannot restore wasted muscles, can reduce or postpone contractures or other side effects of the crippling process; patient inclusion in education programs, influenza inoculations, and transportation for clinic visits, dental appointments, fittings for orthopedic appliances, and to Association-sponsored recreational activities.

Define the Problem

"I think the most important thing we do is define the problem for the patient," said Ludwig Gutmann, M. D., Professor and Chairman of Neurology at WVU School of Medicine. "We let them know whether they have a treatable condition. Some, fortunately, can be helped. We also place great emphasis on research because no treatment has been developed yet for so many of these neuromuscular diseases."

Major tools for diagnosis and research include muscle biopsy and electromyography.

"Doing this for one patient at a time is diagnosis; doing it for many and collecting and learning from the data is research," explained Doctor Gutmann, who conducts electromyography for diagnosis and collects the data for research.

Alexander V. Fakadej, M. D., Associate Professor of Neurology and Pediatrics, is University Hospital's MD Clinic Director, in association with Doctor Gutmann. Also involved is Thomas Crosby, M. D., Assistant Professor of Neurology and Pathology, a clinician who performs muscle biopsies for diagnosis and who conducts research on animal models with S. M. Chou, M. D., Professor of Pathology, Neurology and Surgery.

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Third-Party News, Views and Program Concerns

December Conference On Patient Package Insert Preparation

Currently, the Food and Drug Administration (FDA) requires patient information to be distributed with estrogens, oral contraceptives and isoproterenol inhalation products. In the near future, the FDA will announce its intent to eventually require Patient Package Inserts (PPIs) for a wide range of drug products on the market. The first group of PPIs will be drafted under contract. The FDA will ask bidders to draft prototype PPIs for a few selected drugs.

In order to gather advice from a variety of perspectives regarding the contents and methods of presentation for PPIs, the FDA is sponsoring a conference December 11-12 at the Shoreham Americana Hotel in Washington, D. C.

This conference will be focused specifically on how to choose contents and methods of presentation for selected prototype drugs. Input from health professionals, consumers and other interested parties is solicited.

Registration is free but in order to arrange workshops, preregistration is heavily encouraged. Requests for information and registration forms should be directed to: Ms. Ann Myers, HFD-107, Food and Drug Administration, 5600 Fishers Lane, Rockville, Maryland 20857, Telephone (301) 443-6004.

FDA Recommends Ipecac Syrup In The Home

The United States Food and Drug Administration recently proposed new labeling requirements for ipecac syrup, a nonprescription drug used to induce vomiting in accidental poisonings.

The proposal is coupled with a recommendation from Donald Kennedy, Commissioner of Food and Drugs, urging all consumers to keep a supply of ipecac syrup in their medicine chests to use in cases of accidental poisonings.

Doctor Kennedy said, "We have reviewed ipecac syrup as part of our massive re-evaluation of all nonprescription drugs and have concluded that the drug is safe and effective. We are proposing new labeling for this antidote so that consumers will be able to make better use of it."

Doctor Kennedy continued: "Ipecac syrup should be in every medicine chest, especially in homes with small children. In cases of accidental poisonings, ipecac syrup can be a life-saving drug."

Under the FDA's proposed requirements, labeling for ipecac syrup would urge consumers to call a physician, poison control center or emergency room for advice before using it.

The labeling also warns that ipecac syrup should not be used if strychnine, corrosives such as lye and strong acids, or petroleum distilltaes such as kerosene, gasoline, paint thinner, or cleaning fluid have been ingested.

The FDA is proposing that ipecac syrup be marketed in containers of one ounce or less. The recommended dose for infants under one is one to two teaspoons followed by a half to a full glass of water, and for children over one and adults one tablespoon followed by one to two glasses of water. The dose should be repeated if vomiting does not occur in 20 minutes. If the second dose fails to induce vomiting, the advice of a physician should be sought.

New CHAMPUS Form

Initial quantities of a new claim Form 500 for physicians and other individual providers are being distributed by the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) for immediate use, according to the CHAMPUS claims processing contractor for this area, CHAMPUS Division, Mutual of Omaha, Dodge at 33 Street, Omaha, Nebraska 68131; phone (402) 978-2089.

The new form, for reporting services and supplies furnished by professional (non-institutional) providers and suppliers to CHAMPUS beneficiaries and to beneficiaries of the Civilian Health and Medical Program of the Veterans Administration (CHAMPVA) replaces Form 1863-2. The old claim form, 1863-2, will be phased out over the next several months. It will not be accepted after January 31, 1979.

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County Societies

CENTRAL WEST VIRGINIA

The Central West Virginia Medical Society met on July 28 at the Cherry Hill Country Club in Richwood.

The Society approved a $50 contribution to the Newman H. Dyer Scholarship Fund for 1978, $50 for a sustaining membership in the American Medical Student Association, and a $115 scholarship to Camp Kno Koma. — Joseph B. Reed, M. D., Secretary-Treasurer.

* * *

McDOWELL

The McDowell County Medical Society met on September 13 at the Stevens Clinic Hospital in Welch.

Dr. Richard O. Gale discussed the initiation of the hospital's participation in the Ohio Medical Education Network (OMEN), the electronic continuing medical education program linking hospitals with faculty at four Ohio medical schools.

Dr. John A. Anziulewicz, radiologist from the Bluefield Sanitarium Clinic, presented the scientific program on "Ligamentous Anatomy of the Ankle."—Muthusami Kuppusami, M. D., Secretary.

* * *

CABELL

The Cabell County Medical Society met on September 14 at the Gatewall Inn in Barboursville.

Dr. Thomas F. Scott made an announcement concerning an upcoming two-and-a-half-day continuing medical education seminar dealing with strokes, orthopedic injuries and burns.

Dr. Lawrence B. Gang gave an up-dated report on the Dr. Albert C. Esposito lectureship, with members encouraged to send contributions to the treasurer of the Society.

Frank Ellwood, head football coach at Marshall University, then gave a very interesting and entertaining talk on the football program at MU and the need for physician support, particularly

(Continued On Page xx)

BRIEF SUMMARY OF
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Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13 μg/ml) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

The drug has not been extensively studied in children under two years; therefore, in the treatment of children under the age of two years, the relative benefit/risk should be considered.

Precautions: Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with preexisting liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

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COUNTY SOCIETIES—
Continued From Page xviii

in regard to management of injuries and illnesses among athletes. Discussion ensued.—William J. Echols, M. D., President.

* * *

MONONGALIA

The Monongalia County Medical Society met on September 5 at Lakeview Country Club near Morgantown. Dr. Robert D. Hess of Clarksburg, President of the West Virginia State Medical Association, was the guest speaker.

Mr. Tom Auman of Charleston, Account Supervisor, Aetna Life and Casualty Company, the State Medical Association's carrier for malpractice insurance, discussed the state insurance program and answered questions.—Barbara Jones, M. D., Secretary.

Advises Periodic Rest Periods From Contact Lenses

Long-time wearers of contact lenses should, perhaps, put them aside for some months every few years, advises a research report in a recent issue of Archives of Ophthalmology, a publication of the American Medical Association.

The problem, says Dr. Michel Millodot of the University of Wales, Cardiff, is that the cornea loses sensitivity under constant wearing of hard contact lenses.

"This places these persons at greater risk of having an infection occur without their being aware of it," Doctor Millodot points out.

The Welsh study evaluated 91 individuals who had worn lenses for up to 22 years, plus a control group. Corneal sensitivity diminished in proportion to the number of years the lenses were worn, he found.

Fortunately, sensitivity returns to normal when the lenses are put aside. After only one or two years of wear, recovery occurs overnight. After more than ten years of wear, recovery takes several months.

"Advising patients to put aside their lenses for some months after having worn them for many years may be worthwhile," Doctor Millodot concludes.

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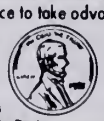

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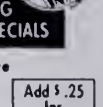

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The West Virginia Medical Journal

Vol. 74, No. 12 December, 1978

Management Of Renal Staghorn Calculi By Anatrophic Nephrolithotomy

JOHN A. BELIS, M. D.
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The "silent staghorn calculus" poses a significant risk to loss of renal function. Early surgical intervention with complete removal of the calculus assures maximal nephron preservation. The surgical technique of nephrolithotomy and three illustrative cases are presented. A review of the literature confirms the position that anatrophic nephrolithotomy offers a safe alternative to nephrectomy in the management of staghorn calculi.

The concept of the "silent staghorn calculus" is a misconception that only recently has been conclusively reversed. Renal staghorn calculi are neither silent nor without risk. Expectant treatment leads to enforced nephrectomy in 50 per cent of cases and death in a significant number of the remainder from progressive renal failure.[1] Patients with staghorn calculi are in constant danger of pyonephrosis, sepsis, development of carcinoma of the renal pelvis,[2] and gradual atrophy of renal parenchyma with eventual chronic renal failure.

Modern technological developments such as local hypothermia, microsurgery, improved roentgenography, better antimicrobials, and more thorough metabolic evaluation have permitted the urologic surgeon to remove extensive renal calculi through anatrophic nephrolithotomy, achieve renal reconstruction, preserve renal function, and reduce the incidence of recurrent calculi.[3] A number of series of nephrolithotomies for staghorn calculi with successful preservation of renal function have now been reported.[3,4] The goals of such conservative renal surgery are to minimize damage to functioning nephrons, eradicate urinary infection, and to relieve urinary obstruction.[5] Indications for nephrectomy for renal calculi are rare and, particularly with infectious calculi, there is little need for lower-pole partial nephrectomy.[4]

To this end, 15 anatrophic nephrolithotomies for extensive renal calculi were performed in 14 patients at West Virginia University Medical Center during the year preceding this writing. One patient had bilateral nephrolithotomies for staghorn calculi performed in separate operations three months apart. The technique of anatrophic nephrolithotomy will be outlined, selected cases presented, and the results and advantages of this procedure, according to previously documented large numbers of cases, will be discussed.

Surgical Techniques

The surgical technique is similar to that as described by Boyce and Elkins.[3] Through a twelfth-rib flank incision. the kidney is mobilized, and the renal pedicle is skeletonized. Twenty-five mg. of mannitol are given intravenously 10 minutes before anticipated renal artery occlusion. This is intended to increase the glomerular filtrate osmolarity and to decrease the chance of ice crystallization within the renal parenchyma. Two hundred units of Heparin in five cc. of normal saline are injected into the main renal artery prior to occlusion with a noncrushing Satinsky renal pedicle clamp. A sterile vidrape is then placed about the flank wound. The kidney is bathed in iced saline slush for 20 minutes. A temperature between 7 to 17° C. is maintained throughout the procedure. A vertical nephrotomy incision is then made one cm. posterior to Brodel's line, exposing the collecting system.

The offending calculus is isolated and removed with Randall stone forceps. The calyces are irrigated with normal saline to remove any residual calculus debris. If there is any question regarding retained stone fragments, an intraoperative portable x-ray is taken of the involved kidney.

Next, the pedicle clamp is loosened, and obvious bleeding points are suture-ligated with 4-0 chromic catgut. The collecting system is closed with a running 4-0 chromic suture. Extreme care is taken to attain a watertight closure without compromising calyceal patency. A calycoplasty is performed when indicated. After the pedicle clamp and vidrape are removed, the nephrotomy incision is closed with running 4-0 chromic catgut. A Penrose drain is placed in the renal fossa, and the incision is anatomically closed in individual layers. A nephrostomy tube is not routinely employed.

Case One

E. V., a 50-year-old, Caucasian female presented with a one-year history of recurrent urinary tract infections and a two-month history of left flank pain. The patient was afebrile, and physical exam was within normal limits. Complete blood count, serum chemistries and electrolytes were all within normal limits. Urinalysis showed an occasional red blood cell and 5-10 white blood cells per high powered field. Urine culture grew 45,000 colonies of *E. coli* per cc., which was effectively treated with Gentamicin. Plain abdominal film demonstrated a left staghorn calculus (Figure 1). A left anatrophic nephrolithotomy was performed. Nine months

Figure 2. Case 1: KUB film shows no recurrent calculi.

Figure 1. Case 1: KUB reveals a left staghorn calculus.

Figure 3. Case 1: IVP demonstrates distortion of the left collecting system.

postoperatively, a plain abdominal film revealed no evidence of recurrent calculi (Figure 2). A 20-minute intravenous pyelogram film showed blunting and distortion of the left collecting system, with associated decrease in left renal size due to previous longstanding obstruction (Figure 3). The patient was free of infection nine months postoperatively.

Case Two

R. S., a 60-year-old, Caucasian female was referred for evaluation of recurrent urinary tract infections with known bilateral renal calculi of at least six years' duration. A right pyelolithotomy was performed at another hospital two months prior to her referral. Physical examination was unremarkable. Admission BUN was 24 mg. per cent and creatinine was 1.4 mg. per cent. Complete blood count and urinalysis were within normal limits. Urine culture revealed no growth at 48 hours. A left staghorn calculus and a five-mm., lower-pole right renal calculus were noted on KUB film (Figure 4). The patient underwent a left nephrolithotomy. Three months postoperatively, a plain abdominal film showed no recurrent left ureteral calculi, and the right lower-pole calculus remained unchanged (Figure 5). An IVP seven months later demonstrated prompt bilateral function with blunting of the calyces in both kidneys, secondary to chronic inflammatory changes (Figure 6). The patient's urine is currently sterile without antibiotic suppression.

Figure 5. Case 2: No recurrent left renal calculi are visible postoperatively.

Figure 4. Case 2: Left staghorn calculus and five-mm., right, lower-pole calculus are noted on KUB film.

Figure 6. Case 2: Chronic inflammatory changes with bilateral calyceal blunting are noted.

Case Three

B. S. M., a 28-year-old, Caucasian female presented with a five-year history of recurrent episodes of left pyelonephritis. The patient was afebrile at the time of initial physical examination. Complete blood count, serum chemistries and electrolytes were within normal limits. Urinalysis revealed numerous WBCs and bacteria per high-powered field. Admission urine C & S grew greater than 100,000 colonies per cc. of Proteus mirabilis. This infection was readily eradicated with Gentamicin. Plain abdominal film documented the presence of bilateral staghorn calculi (Figure 7). A left nephrolithotomy was performed. Postoperative film showed no residual left renal calculi, and the right staghorn calculus remained unchanged (Figure 8).

Discussion

Staghorn calculi produce gradual irreversible renal damage. As many as 69 per cent of patients with extensive renal calculi have demonstrated urinary tract infection, while fever, pain, or hematuria occur in a majority.[3] These patients are in constant danger of pyonephrosis, perinephric abscess, and septicemia, as well as chronic renal failure, since leaving a stone *in situ* with concomitant infection also poses a threat to the opposite kidney.[1] The overall mortality of patients with extensive renal calculi is greater with observation than with surgery.[2] Therefore, surgery is better for the kidney and the patient.

Figure 7. Case 3: Bilateral staghorn calculi are present on KUB film.

Figure 8. Case 3: No residual left renal calculi are seen on this postoperative KUB film.

All patients are screened for metabolic abnormalities and treated appropriately. Intensive parenteral antimicrobial therapy based upon urine culture and sensitivity is initiated preoperatively. Preoperative anterior-posterior, lateral, and oblique x-rays of the kidney during excretory urography are necessary to identify calyceal arrangement.[5] Preoperative renal angiography is helpful in delineating the anatomy of renal arteries which may occasionally be anomalous,[6] and in identifying the surgical plane of least vascularity. Intravenous mannitol given 5 to 10 minutes prior to renal artery occlusion appears to decrease the incidence of postoperative oliguria.[7,8] Local administration of Heparin, 200 units in five cc. normal saline, into the renal artery just prior to occlusion decreases the incidence of intrarenal microthrombosis.[9] Renal cooling to a maintenance temperature of 7 to 17° C. is essential to renal preservation.[10]

After removal of all visible calculi, roentgenography of the exposed kidney should be performed to assist in finding small stone fragments. Attempts should be made to remove all fragments, but should not be pursued to a point of unacceptable renal trauma. Good postoperative hemostasis should be obtained by suturing visible end vessels in the renal parenchyma with fine

chromic catgut. Blood loss with the procedure was generally less than 500 ml. Nephrostomy tubes should be avoided. When nephrolithotomy is performed upon an azotemic patient, or in a patient with solitary kidney, extracorporeal dialysis should be readily available.

Following recovery from surgery, persistent follow-up is critical. Of greatest importance is the prevention of recurrent urinary infections, particularly proteus infections which may rapidly lead to formation of new intrarenal calculi. This appears to be best achieved by maintenance prophylactic antimicrobials for a minimum of one year along with monthly urine cultures to permit rapid initiation of treatment of new infections.

In the series of 15 nephrolithotomies performed at West Virginia University Medical Center, no operative deaths or postoperative complications such as hemorrhage, wound infection, or urinary fistula have been encountered. All patients are currently being followed closely in the outpatient clinic. No recurrent calculi have been noted to date.

Summary

Nephrolithotomy by the procedure described is a safe and accurate technique. All calculi can be removed from the calyces and pelvis under direct vision with minimal destruction of renal tissue. Morbidity and mortality is as low as with any other procedure for removal of similar stones, while recurrence of calculi is comparable to the lowest recurrence rate for other operations for renal calculi.

The concept of "silent staghorn" is a false one. Early and complete removal of calculi is indicated. As the primary goal in renal calculus surgery is renal preservation, and because calculus formation is generally a process which involves both kidneys, every effort should be made to avoid nephrectomy.

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The Use Of Profound Hypothermia In The Correction Of Congenital Heart Defects In Infancy*

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In the past few years the use of profound hypothermia has proved increasingly popular for the repair of congenital heart defects in early infancy. Many major centers now have a large series of infants operated upon in this way, and the long-term follow-up of the infants has revealed no neurological sequelae attributable to the use of profound hypothermia.[10]

Current concepts related to the use of profound hypothermia in cardiac surgery are discussed, together with case selection and a short description of methodology.

HYPOTHERMIA for repair of congenital heart defects is not new. It was first reported by Lewis and Haufig in 1952 for repair of atrial-septal defect.[1]

The advent of pump-oxygenators and subsequent improvement in their design led to a decrease in the use of hypothermia for cardiac surgery even though some, such as Drew,[2] continued to use the technique for both adult and pediatric cases. However, the technical difficulties and high mortality associated with conventional cardiopulmonary bypass in small infants led to a renewed interest in the application of profound hypothermia for open heart surgery in babies and small infants.

Selection of Cases

The patients selected for this technique are generally less than 10 kilograms in weight and under two years of age, although these limits are not necessarily absolute. The lesions requiring correction in this age group are generally cyanotic ones and include transposition of the great arteries, total anomalous pulmonary venous connection, Fallot's Tetralogy, truncus arteriosus, double outlet right ventricle, and total A-V canal. Large ventricular septal defects causing either intractable congestive heart failure or associated with high pulmonary vascular resistance are also suitable for this technique.

It must be emphasized that these infants are often desperately ill, and surgery offers the only hope of survival once medical treatment has proven unsuccessful. Therefore, the mortality rate reported in these infants is high and in most series averages 50 to 60 per cent, with virtually 100 per cent mortality in such conditions as total anomalous pulmonary venous connection with drainage below the diaphgram.

Technique

The technique employed at West Virginia University Hospital is essentially that developed at the University of Kyoto in Japan[3] and subsequently modified by Barrett-Boyes and his group at Greenlane Hospital, Auckland, New Zealand.[4] It is fairly well standardized in most major centers.

The infant is anesthetized with nitrous oxide, oxygen and halothane 0.3 per cent. Maintenance is with D-Tubo Curarine. This is used in order to prevent the infant from shivering, with the subsequent rise in oxygen consumption. Suitable cannulae are placed in the radial artery and internal jugular vein by percutaneous puncture if possible, but sometimes by cutdown in very small infants. Thermistor probes are placed in the mid-esophagus, nasopharynx and rectum. Surface cooling is commenced with ice bags or a water bath to an esophageal temperature of 30 degrees Centigrade. Five per cent carbon dioxide is added to the anesthetic mixture at 32 degrees Centigrade in order to promote peripheral vasodilatation and to maintain the correct relative position of the oxy-hemoglobin dissociation curve. Surface cooling is employed to provide a more uniform cooling process. Median sternotomy is performed at 30 degrees Centigrade and the infant placed on cardiopulmonary bypass using aortic root and right atrial cannulation. The pump-oxygenator is primed with fresh Heparinized blood and lactated Ringers solution so as to provide a hematocrit of 30 per cent during cardiopulmonary bypass, since this

*This paper was written while Doctor Entress was Assistant Professor, Department of Anesthesiology, West Virginia University School of Medicine, Morgantown.

degree of hemodilution results in optimal tissue perfusion at low temperatures. It is important to avoid the use of dextrose in the prime since the normal response to hypothermia is a marked hyperglycemia due to depression of insulin release[5] and also decrease in peripheral utilization of glucose. A high blood sugar can result in serious osmotic disturbance postoperatively. Five millequivalents of potassium and 10 millequivalents of sodium bicarbonate are added to the prime to provide optimal pH and electrolyte balance during cardiopulmonary bypass. Some centers add Methylprednisolone, four mg. per kilogram, to the prime also.

Cooling is commenced at a rate of one degree Centigrade per minute, maintaining a temperature difference of less than 10 degrees Centigrade between esophageal and perfusate temperatures. Five-per-cent carbon dioxide is added to the oxygenator during bypass. Urine output is maintained at one ml. per kilogram per hour using small doses of Furosemide if necessary. Once the desired temperature is reached, usually 15 to 20 degrees Centigrade, perfusion is maintained for five minutes at that temperature, and then cardiopulmonary bypass is discontinued. The heart, which is now in asystole or very slow sinus rhythm, is drained into the oxygenator and repair of the lesion takes place in a still, dry heart. A left atrial pressure line and epicardial pacemaker wires are routinely inserted. Following repair of the lesion, cardiopulmonary bypass is re-instituted and the infant is rewarmed to 36 degrees Centigrade (which generally takes one and one-half to two times as long as the cooling process) and at which temperature the infant is gradually weaned from cardiopulmonary bypass, maintaining a left atrial pressure between 10 and 15 mm. of mercury. The use of an inotropic agent such as Dopamine or Isoproterenol is sometimes necessary at this point. Generally speaking, the heart either resumes sinus rhythm spontaneously or, if in ventricular fibrillation, is very easily converted. The infant is then taken to the Intensive Care Unit where mechanical ventilation is generally maintained for 24 to 48 hours postoperatively.

Metabolic Effects

The safe period of circulatory arrest is generally held to be one hour at 20 degrees Centigrade and one and one-half hours at 15 degrees Centigrade.[6] Cerebral integrity is maintained during the period of circulatory arrest by three mechanisms:[7] (1) there is a reduction in cerebral oxygen consumption so that at about 20 degrees Centigrade cerebral oxygen consumption is only about 20 per cent of nomal; (2) the reduced cerebral metabolic needs for oxygen can be largely met by the increase in the oxygen content of the plasma due to increased oxygen solubility at low temperatures (There is a 14 fold increase in the solubility of oxygen at 10 degrees Centigrade compared to 37 degrees Centigrade), and (3) anaerobic metabolism does undoubtedly occur during the period of circulatory arrest as evidenced by increase in serum lactate levels[8] and a decrease in bicarbonate levels. These abnormalities are generally corrected during the period of rewarming; however, it is sometimes necessary to correct the metabolic acidosis with sodium bicarbonate. Very recently, it has been suggested that increasing the cerebral glycogen content, which is the substrate for anaerobic metabolism, can prolong the safe period of circulatory arrest.[9] The preoperative infusion of glucose and insulin has been shown to increase cerebral glycogen in experimental animals by up to 30 per cent, and so far the use of this regimen in children undergoing profound hypothermia has proved encouraging.

An increase in pH is associated with hypothermia together with hypokalemia, which may be responsible for some dysrhythmias which are occasionally seen.[6] It is therefore important to monitor serum potassium levels during the cooling process.

Mortality

Mortality varies greatly according to the age of the patient and the nature of the lesion. Generally, mortality is much higher in infants operated on under one month of age; mortality rates for the various lesions range from approximately 15 per cent for V. S. D. closure to greater than 90 per cent for total anomalous pulmonary venous connection below the diaphragm. The youngest survivor at WVU has been an infant with total anomalous pulmonary venous connection who was operated on successfully at the age of two weeks. Other lesions successfully treated with the technique at WVU in children under one year include transposition of the great vessels, total atrio-ventricular canal, and massive ventriculo-septal defect.

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Manuscript Information

Manuscripts to be presented for publication in *The West Virginia Medical Journal* should be typewritten, triple-spaced, on one side only of firm (no onion skin or flimsy), standard letter sized (8 1/2 by 11 in.) white paper. Wide margins (at least 1 1/4 in. on left) should be left free of typing. On the first or title page should be shown the title of the article, the name (or names) of the author, and his degrees. Pages should be numbered consecutively, the page number being shown in the right upper corner along with the surname of the author.

Where reference is made to generically-designated drugs, the first such reference must be followed by parentheses containing the most commonly known trade-name drug of that designation. In addition, a listing of all generic drugs mentioned in the article, with their trade-name equivalents, should appear at the end of the article.

A short abstract summarizing the manuscript should be included. This should be typed in double space on a separate page.

Authors are requested to submit a carbon copy with the original.

Illustrations should be numbered and their approximate locations shown in the text. Each should be identified by placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for reproduction should be done in black (India) ink on pure white. Photographs should be on glossy paper and minimum of about 5 by 7 in. in size. A legend should be provided for each illustration and, preferably, attached to it.

All scientific material appearing in *The Journal* is reviewed by the Editorial Board. Manuscripts should be mailed to The Editor, West Virginia Medical Journal, Box 1031, Charleston, W. Va. 25324.

Special Article

State, National Trends in Liability Claims*

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TODAY, I would like to discuss claim trends in the field of professional liability as they pertain to physicians in their particular specialty.

Before going into this, however, I would like to take a minute to tell you what has been going on around the country. It appears, at least from our records, that we hit a peak insofar as frequency is concerned in June, 1976. Since that time the frequency of claims has dropped somewhat and has remained almost level. However, the severity of claims has been on the rise. An example of this is that in 1973 our average paid jury verdict was $44,444 per case. In 1977, the average jury verdict was $197,533. Another example: in 1962, the United States had its first million-dollar personal injury judgment. By January 1, 1970, there were 20 such judgments. From January 1, 1970, through December, 1977, there were an additional 185. Twenty-eight of these, or approximately 14 per cent, were medical malpractice cases. While there are no records for this year, it is my understanding that they are still climbing. I call this to your attention to make you AWARE.

Since a large portion of a physician's time is spent in a hospital, it is not surprising that the vast majority of malpractice claims arise from incidents which occur while a patient is hospitalized. The 1975 All-Industry Study of 10,000 medical malpractice claims closed in 1974 indicated the hospital to be the scene of 81 per cent of the situations precipitating the filing of those claims. Fifty per cent of those claims arose from incidents occurring in the operating room; 15 per cent occurred in patients' rooms, and 12 per cent originated in the Emergency Department.

I am sure you also recall that both the U. S. Department of Health, Education and Welfare Commission Report on medical malpractice in 1971, and the All-Industry Study in 1975, identified real error on the part of the physician as the primary cause for malpractice litigation. What errors occur? What are the vulnerable areas in the various fields of medical practice?

The Medical Division of Aetna Life & Casualty Company's Claim Department has been attempting to identify the various vulnerable areas in the different medical specialties since 1969. At that time the Division commenced a study that now has encompassed over 3,000 closed claim files. We believe that at least some of the information derived from this study can be utilized advantageously by many health care professionals. That's because the study does help identify certain situations which tend to produce allegations of medical malpractice rather frequently. If these situations can be avoided successfully in your practice, you might be able to rest easier despite the litigious society in which we live.

We now provide the physician-members of nine state medical societies with professional liability coverage through their societies, and concurrently provide the hospital members of three state hospital associations with professional liability coverage in like manner. We are concentrating our studies on the malpractice claims generated by those societies and associations while decreasing somewhat the scope of our study of closed malpractice claims from other states. Time and manpower restrictions dictate that we do so.

Most Incidents in Hospital

Our studies show that most medical malpractice incidents occur in hospitals. The vast majority of these are concentrated in three areas—the operating room—the patient's room—and the Emergency Department. Furthermore, the central issue in most claims we see today hinges upon the quality of care. Today's health-care consumer does not tolerate a poor result.

Loss of rapport, plus a poor result, often sets the scene for a malpractice claim, particularly in today's medico-legal climate. If those of you who are involved with a patient's health care in your office, clinic or hospital fail to maintain good rapport with your patients and fail to keep them apprised of their progress and the reasons why their clinical course may not be progressing

*This paper was delivered at the Greenbrier, White Sulphur Springs, West Virginia, on August 23, 1978, during the 111th Annual Meeting of the West Virginia State Medical Association.

as initially expected, the patients well might feel frustrated. The longer they are kept in the dark about what is occurring and its whys and wherefores, the more frustrated and disgruntled they might become. Finally, out of sheer frustration, and due to complete loss of rapport between the physician and the patient, a lawsuit might ensue. Loss of rapport, coupled with a poor result, currently triggers a good portion of the malpractice claims. It was not always so.

Causes of Claims

When we first started analyzing medical malpractice closed claim files, we concluded that a physician's greatest risk of having a claim made against him arose because of cases of: 1. unexpected death; 2. paralysis; 3. brain damage; 4. amputation, and 5. blindness. Today, these catastrophes still trigger medical malpractice actions, and, indeed, account for some of the largest verdicts when malpractice has been proved to the jury's satisfaction. However, such cases are in the minority of the 4,000 plus new cases which open for our company each year.

Let's now examine some of our case study results in more detail. For instance, for anesthesiologists, the majority of allegations of malpractice currently are triggered by claims of improper treatment, particularly as indicated by the fractured, chipped, or missing teeth that follow some endotracheal intubations. The other causes of malpractice allegations that are common for anesthesiologists are: cardiac arrest; spinal anesthesia complications; eye injuries; pneumothorax, and nerve palsy or paralysis secondary to positioning. To these we would add a currently growing claim category: alleged misuse of anesthetic agents causing serious anesthetic drug reactions.

At present, it seems that the anesthesiologist's best medico-legal safeguards are: 1. constant clinical vigilance; 2. prompt corrective response to any abnormal physiologic event recorded during the anesthetic procedure; 3. constant application of good medical judgment to each and every emergency situation encountered, and, 4. well-documented anesthetic records.

General Practitioners

Let's now examine the change in basic allegations of malpractice for general practitioners that we have experienced since 1963. As a result of studies of medical malpractice claims closed nationwide, we determined that general practitioners were most vulnerable to allegations of malpractice in cases of: 1. drug prescribing or dispensing errors, most often with these resulting from telephoned prescriptions to pharmacists; 2. falls on office premises before, during, or after examination and treatment; 3. allegations of missed diagnoses or improper treatment of fractures or dislocations; 4. retained foreign bodies in tissue spaces; 5. injection site injuries to peripheral nerves; 6. missed diagnoses, other than of fractures or dislocations, and 7. improper commitment.

Our study of experience from the nine state medical societies we insure necessitates a revision of this list. Claims of malpractice against general practitioners now most frequently occur because of allegations of: 1. improper treatment; 2. missed diagnoses; 3. drug reactions; 4. poor results; and, lastly, 5. medication errors. Sometimes that which appears most simple results in a relatively difficult claim problem. One general practitioner's case proved expensive to settle although it had arisen innocently enough. A patient presented for cleansing and suturing of a recent injury, a dirty laceration. The wound care was adequate and, of itself, measured up to an appropriate standard of care. However, failure to initiate preventive measures against tetanus almost ended fatally for the patient involved. Hence, an expensive settlement resulted.

Gynecologists, Surgeons

Complaints of a poor result or of improper treatment currently also lead the list of allegations of professional negligence for gynecologists, orthopedic surgeons, neurosurgeons and plastic surgeons, as well. Conditions triggering the largest number of malpractice actions for general surgeons and for the particular hospital where such problems arise were: 1. complications following arteriograms; 2. retained foreign bodies; 3. missed diagnosis; 4. alleged improper treatment; 5. postoperative infections, and 6. cardiac arrest.

All surgical specialists have to contend with an allegation specific to their fields of endeavor, i. g., retained foreign bodies. Our most unusual case involving a retained sponge occurred following a laminectomy. A few weeks after the original surgery, a sponge was identified as the cause of continuing complaint of back pain and sciatica. It was retrieved. However, much to the chagrin of patient, surgeon, and hospital alike, another sponge was left behind as the original one was being retrieved. The patient naturally sought revenge—revenge that was costly for the surgeon and the hospital.

Internists

Although internists who have reported malpractice allegations to us to date do not experience allegations of malpractice as frequently as those physicians at higher risk, they do experience medico-legal difficulty from time to time.

They are most frequently at risk of suit in instances of allegations of: 1. missed diagnosis; 2. adverse drug reaction; 3. improper treatment, and 4. poor results. Probably one of the most unusual incidents occurred because of failure of a fail-safe temperature control device on a peritoneal dialysis machine. The resultant excessive temperature of the dialysate being pumped intraperitoneally produced a fatality. The patient was literally baked.

The field of obstetrics and gynecology produces for us the greatest number of malpractice allegations. They are: 1. delivery mishaps; 2. poor results; 3. laparoscopy complications; 4. missed diagnosis; 5. retained foreign bodies; 6. improper treatment; 7. medication errors, and 8. drug reactions. Burns of the abdominal wall, perforated intestines with peritonitis, and pregnancy following laparoscopic tubal ligation are prominent among the various problems reported to us following laparoscopic surgical procedures.

Next, let's look at the orthopedists. A study of 250 closed orthopedic malpractice cases was made by Dr. David Kellsey, Associate Medical Director of Aetna Life & Casualty, and was presented to the American Academy of Orthopedic Surgeons. The categories of cases which made the orthopedist vulnerable to malpractice claims were: poor results, 74 cases or 29 per cent; improper treatment, 70 cases or 28 per cent; back surgery, 26 cases or 10.4 per cent; diagnostic errors, 26 cases or 10.4 per cent; postoperative infections, 31 cases, 12.4 per cent; miscellaneous postoperative complications, 16 cases, 6.4 per cent; and cardiac arrest, 7 cases, 2.8 per cent. Over 50 per cent of these claims were triggered by allegations of presumed improper treatment or poor results.

Orthopedists, by the nature of their training, are supposedly expert in the diagnosis and treatment of fractures and dislocations. Failure in this regard can often lead to allegations of malpractice. Diagnostic errors in two cases of congenital dislocation of the hip resulted in expensive claims. The same was true in two instances of missed diagnosis of central fracture dislocation of the hip in automobile accident victims hospitalized because of multiple soft tissue and musculoskeletal injuries. Such cases emphasize the fact that more is missed by not looking than by not knowing.

In West Virginia

Now, let's see what is going on in West Virginia. I have taken the liberty of picking out the four major categories in your state and showing the losses involved. In all of the information I shall present, the category of poor results includes unexpected death in each of the specialties involved.

General Surgery, 73 claims: poor results, 28.8 per cent; surgical error, 20.5 per cent; misdiagnosis, 20.5 per cent; retained foreign object, 8.2 per cent, and equipment involvement, 6.8 per cent.

Family Practice, 45 claims: misdiagnosis, 28.9 per cent; improper treatment, 28.9 per cent; poor results, 12.3 per cent, and medication error, 11.1 per cent.

Obstetrics/Gynecology, 44 claims: surgical or treatment error, 34.1 per cent; poor results, 22.7 per cent; misdiagnosis, 11.4 per cent; pregnancy-improper sterilization, 9.1 per cent, and birth-damaged infant, 7.0 per cent.

Orthopedic Surgery, 19 claims: surgical or treatment error, 63.1 per cent; misdiagnosis, 15.8 per cent; equipment involvement, 10.5 per cent; poor results, 5.2 per cent, and infection, 5.2 per cent.

You probably noticed that many of the categories involved in countrywide statistics are popping up in the West Virginia study.

You may ask, "Where does all this leave us?" In my opinion, for the prudent physician interested in malpractice claim prevention related to his own practice, the answer would have to come in three parts. There is nothing new or magical about any of these—most of you have heard at least some of it before.

Rules for Avoiding Allegations

First, there are nine general rules for avoiding malpractice allegations, claims or suits. Generally speaking: 1. You can usually decline to accept a patient, particularly if his case is not within your area of professional competence. 2. However, once you accept the patient, you must adhere to the generally accepted standards of practice. 3. Keep good records in your office, clinic, and hospital charts. Complete documentation of your patient's problems and your findings, recommendations and treatment is imperative. Records are witnesses that never die. Remember, doctors do die. The integrity of their estates rests upon

the adequacy of the medical records they leave behind. 4. Never guarantee a cure. 5. Be sure to inform the patient of any hazards of treatment. Put it in a statistical frame of reference if at all possible. Document your records when you obtain the informed consent of your patient to follow a particular course of treatment. 6. Get explicit permission before clinical experimentation. 7. Don't be hesitant about consultations. Be sure they are recorded. 8. Cooperate with your profession. 9. Maintain good rapport with your patients and with the public.

The *second* part of the answer is: never forget the "three R's." These are: 1. Rapport. Many minor incidents that arise during patient care which might expose you to allegations of malpractice can often be avoided by a pleasant bedside and chairside manner. Pleasant patient relations at all times—never recriminations or antagonism—are imperative. 2. Records. Make and maintain accurate records. The absence of appropriate medical documentation supporting your decisions, diagnosis and treatment makes the defense of a claim against you more difficult even if you were right. 3. Reason. Your strongest ally against malpractice incidents is the exercise of good reason and good professional judgment when you commence treatment. Your best judgment, not the patient's or family's wishes, should always prevail.

And, *third and last*, I believe, an important observation is in order: From our claim experience we have found that careful patient appraisal; good patient rapport; the exercise of good clinical judgment at all times; careful and impeccable surgical techniques or medical management; and prompt, appropriate and personal response to the patient's complaints, plus careful documentation of the medical records in office, clinic and hospital, prove the difference between good and poor claim results for our insured physicians.

Thank you for your attention.

Linking ECGs With Other Data

RECENT advances in the use of computer analysis of the electrocardiogram (ECG) have prompted growing awareness of the technology's powerful potentials for new and improved clinical applications. In order to develop this potential, cardiologists are calling for standardization of ECG procedures, terminology, and diagnostic criteria; and in addition, they emphasize the need to develop a common data base as well as common methodologies to permit direct comparison of ECG data with other clinical data. These findings by cardiologists, clinicians, engineers, and developmental technologists emanated from a recent national conference sponsored by the American College of Cardiology.

Special Article

Rural Primary Clinic Development In West Virginia*

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West Virginia has made outstanding progress in developing a network of nonprofit, primary care clinics to serve the needs of its predominantly rural population. A total of 63 clinics existed in August, 1978, of which 54 had been developed within the past seven years. Since 26 per cent of all rural primary care physicians within the state are practicing from these clinics, they are a major health resource. It is the purpose of this article to identify and explain important factors in the development of this network of West Virginia primary care clinics.

The Office of Health Services Research (OHSR) at West Virginia University has developed a working definition of the clinics which we have inventoried as: "A not-for-profit medical service unit offering the services of a general practitioner or one of the primary care specialties such as pediatrics, general internal medicine, family practice or obstetrics/gynecology for a minimum of eight hours a week from a fixed location." We have consciously excluded hospital emergency services, public health departments and their traditional clinics and mobile units, and units which are operated primarily for teaching purposes. Multi-specialty groups which offer some primary care were excluded, whereas their extensions that provide predominantly primary care were included in the inventory of primary care facilities.

Although the clinics are not defined on a rural or urban basis, the focus of the study is to meet the medical needs of the rural population of West Virginia. A rural community is composed of a population of less than 2,500 people. This definition is taken from the 1970 census user dictionary which states: "Urban places include all incorporated places of 2,500 or more," while a rural population is "that population which is not classified as urban."

State Slower to Urbanize

The extent of West Virginia's rurality is a factor in the problems and opportunities for primary care development in the State. Since 1950, the rurality of both West Virginia and the nation as a whole has decreased. However, as Figure 1 shows, there has been a disproportionate rate of change from rural to urban between West Virginia and the U. S. In 1950, West Virginia was 1.8 times as rural as the rest of the nation, whereas in 1970, it was 2.3 times as rural. The nation is urbanizing more than twice as fast as West Virginia.

Prior to January 1, 1972, there were nine primary care clinics in operation throughout the State (Figure 2). Seven of the nine were developed with the support of the United Mine Workers of America Health and Retirement Funds; the West Union Clinic was sponsored by the Sears and Roebuck Foundation, and the Pennsboro Clinic was a community initiative. It should be noted that there were no federal or state funds involved in the development of any of these nine clinics.

As of August, 1978, as shown by Figure 3, there were some 63 clinics in operation and nine more in various stages of planning. This repre-

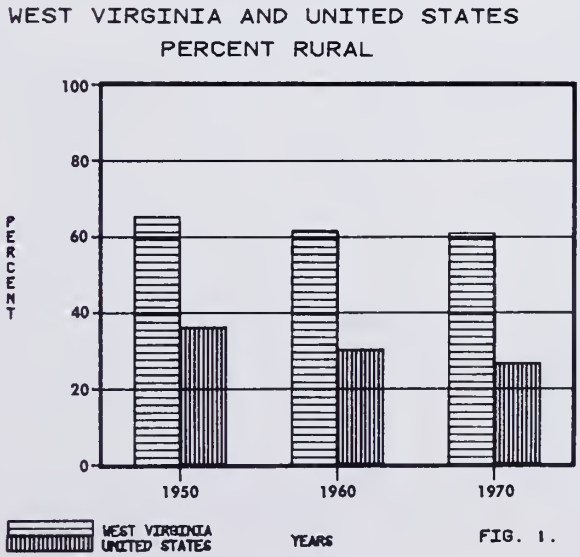
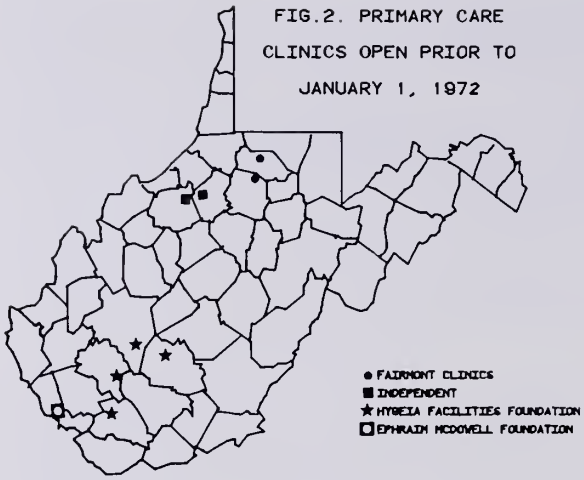


FIG. 1.

*Research funded by the Claude Worthington Benedum Foundation and the Appalachian Regional Commission.



sented an increase of 54 clinics since January, 1972. We estimate that 16 per cent of all rural West Virginians are now within 15 minutes of one of these primary care clinics; and that 26 per cent of all primary care physicians practicing in rural West Virginia are now a part of the non-profit clinic system.

Given the developmental information above, how does the number of clinics in West Virginia compare with neighboring states? By rough comparison, our neighbors Kentucky and Virginia have 13 and nine clinics, respectively. North Carolina and Tennessee, the states whose sum total of clinics most nearly approximates West Virginia's, have 51 non-profit primary care clinics for a rural population of 4,415,000. West Virginia had 63 clinics in August for a rural population of 1,065,000. Thirteen southern states, excluding West Virginia, have approximately 130 non-profit primary care clinics for a rural population of more than 20 million.*

Five Major Factors

Five major factors identified as having contributed to West Virginia's status as a national leader in the provision of primary medical services for its rural population are: (1) UMWA Health and Retirement Rund; (2) an informal coalition for primary care development consisting of the Regional Medical Program, the Appalachian Regional Commission activities funded through the Office of the Governor and the Claude Worthington Benedum Foundation; (3) National Health Service Corps (NHSC) — Foreign Medical Graduates (FMGs); (4) Region III Office of HEW, and (5) evolving rural clinic management systems.

*The non West Virginia clinic figures come from "A Catalogue of Southern Rural Health Delivery Projects" provided by the National Rural Center, revised November, 1975. Clinics that appeared to be comparable to West Virginia's clinics were extracted from the catalogue and used in the above analysis.

The UMWA Health and Retirement Fund has been a dominant factor in non-profit primary care clinic development. This fund has a heritage of advocacy for development. As shown previously, seven of the original nine clinics established were UMWA-Fund related. In addition, 17 per cent, or 304,000 people, of West Virginia's population are UMWA beneficiaries and as a result have had excellent ambulatory medical coverage. Population concentrations of 60 per cent UMWA beneficiaries are common in the southern part of the state and are known to run as high as 80-90 per cent within magisterial districts. There is a clear relationship between the concentration of UMWA beneficiaries and the prevalance of non-profit primary care clinics.

The Office of Health Services Research (OHSR) has data on the first-year developmental costs of 15 clinics in which the West Virginia Regional Medical Program invested funds as well as technical assistance. Between January, 1972, and July, 1976, 15 new clinics utilized a variety of funding sources which included Appalachian Regional Commission, Claude Worthington Benedum Foundation and local funds. A mean developmental cost of $255,000 was incurred to establish each clinic. During this period of time, the Appalachian Regional Commission (ARC), through the Governor's Office for Economic and Community Development, was a major source of primary care clinic development funds and was involved in the establishment of 30 clinics throughout the state.

Of the 63 clinics in West Virginia, 25 are National Health Service Corps (NHSC) sites for physicians. The number of corps physician assignees within the state is another accomplishment to be compared wtih neighborhing states. Although Pennsylvania has a rural population more than three times the size of West Virginia, West Virginia has 31 NHSC physician assignees and Pennsylvania has 30 NHSC physician assignees. Kentucky, with a rural population one and one-half times that of West Virginia, has 10 NHSC physician assignees. An outcome is that West Virginia has a significantly lower rural population to NHSC physician-assignee ratio.

Clinics Dependent on FMGs

West Virginia is heavily dependent upon foreign-trained physicians for the delivery of primary health care. Many of the clinics would not have been able to open had the primary physician manpower pool not been greatly expanded by the influx of FMGs during 1972-75. Statewide, FMGs make up nearly a third (32.6 per cent) of the primary care pool. This con-

tribution is especially relevant in that FMGs make up over half of the primary care pool in 11 of West Virginia's 37 Health Service Regions (HSRs) defined by the Office of Health Services Research (OHSR).

The Region III Office of HEW-Bureau of Community Health Services has been an excellent catalyst in the promotion of rural primary care centers. This office has promoted the Rural Health Initiative (RHI) program throughout the state. In 1978, there are four Health Underserved Rural Areas (HURA) and 17 RHI project sites serving both critical health manpower shortage areas and medically underserved areas. Currently, the Bureau of Community Health Services is a lead agency in the development of primary care replacing ARC as the prime funding source.

The last factor, the clinic management systems, has been and is important to the rational development and responsible management of primary care clinics. Clinic systems exist where there are formal relationships between a central and satellite clinics. Such systems have the capacity to provide more resources for their communities than the solo clinic operation. Optimally, such systems create linkages for continuity of care for the rural patient. There are exceptions, but in general, clinic systems have the ability to overcome two of the most severe problems of primary care clinics—small clinic size and clinic isolation.

These factors have all contributed significantly to clinic development. However, the most important factor has been the availability of federal funds. After federal funds became available, 51 clinics developed within six years. Recently, these clinics have survived two severe winters, some disastrous spring floods and the collapse of the principal source of third-party reimbursement, along with a record strike. None of the clinics has had to close. In fact, several others are presently under development. These clinics represent a major source of primary health care for rural West Virginians.

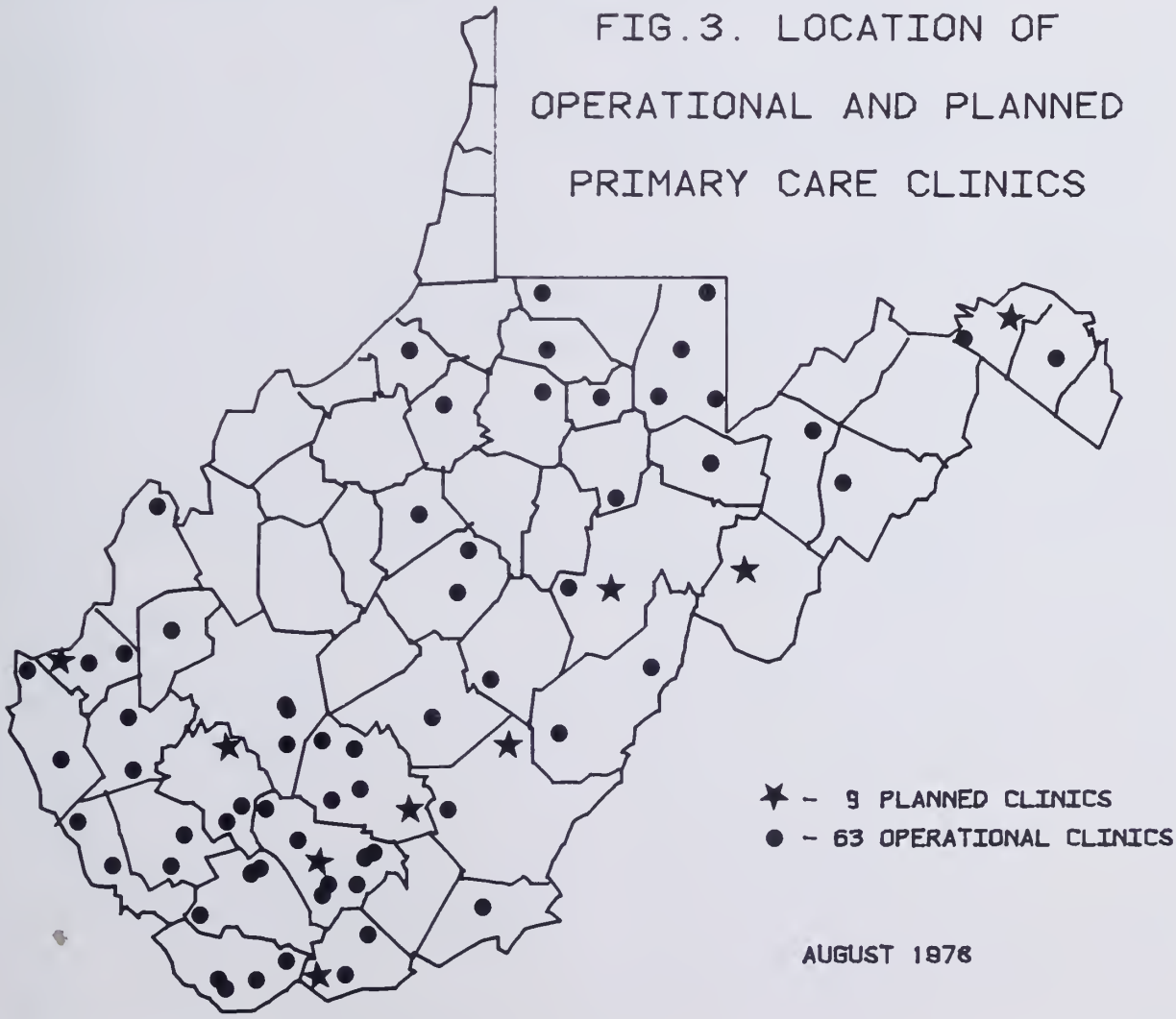


FIG. 3. LOCATION OF OPERATIONAL AND PLANNED PRIMARY CARE CLINICS

A message from . . .

The President

THE MAIN EVENT

THE 1978 General Election is behind us. Upcoming is the main event, the first regular session of the 64th West Virginia Legislature which will get under way January 10 in Charleston. Once again, blue chips representing the future course of health and medical care in the state almost certainly will be on the line.

Before January 10, each physician in West Virginia needs to become acquainted with new legislators from his or her Senate and House district—and to renew contacts with those in hold-over roles.

Members of the Senate and House need to hear from you, their fellow townsmen, friends and personal physicians, about how you feel regarding increased regulatory and other restraints that are handicapping your efforts to provide them and others with quality, accessible care.

Let the lawmakers know, too, how physicians feel about a need for health education in our public schools. And make certain they understand that you'll not only be watching closely legislation related to health and medical care; but always will be ready to provide counsel and assistance they desire in joint efforts toward continued quality care for West Virginians.

Robert D. Hess MD.

ROBERT D. HESS, M. D., *President*

The West Virginia Medical Journal

Editorials

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author shall be held entirely responsible.

We call your attention to this month's Special Article, "Rural Primary Care Clinic Development in West Virginia," an article of some significance.

RURAL HEALTH CLINICS

Most West Virginia medical practices are bounded by fairly set geographical limits. As a consequence our awareness of professional activities tends to be rather parochial. We are aware of what is going on and who is doing what locally. The overall extent of the establishment in West Virginia of a non-traditional, non-private practice form of medical care might therefore come as a surprise to most of our readers.

The fact that 30 per cent of primary care physicians in rural West Virginia are associated with a "non-profit clinic system" is impressive enough, but not nearly as impressive as the fact that almost 90 per cent of these have taken up practice in West Virginia in the past seven years. The dramatic increase is attributed to five factors listed within the body of the text.

Thirty clinics were established using Appalachian Regional Commission funds exclusively, and 15 used a variety of funds including ARC, local and private foundation funds. These latter cost $255,000 per clinic to establish. Figures for the cost of the 30 exclusively ARC-funded are lacking.

Other statistics indicating the degree or extent of continuing subsidization requirements, if available, are not given. These would be of some interest. One item indicating that such subsidization exists is the information that 25 clinics are sites for National Health Service Corps physicians.

The terms "health manpower shortage area" and "medically underserved areas" are employed in the article, but definitions of these terms do not appear. A clear understanding of the phenomenon described requires an understanding of the terms.

Additional areas of interest involve cost and efficiency. One is reminded of these concerns by recent GAO revelations in regard to these matters as they pertain to Community Health Centers, city cousins of Rural Primary Care Clinics.

The article gives pause for consideration of the direction in which the organization of medical care in West Virginia will proceed in coming years.

We invite comment and discussion.

RETURN TO VALUES

Mrs. Alice Jo (Dr. Robert D.) Hess has done far more than just provide a valuable addition to the state's medical lore with her 650-page *History of Medicine in Harrison County, West Virginia.* Granted, the product of some eight years of work is beautifully and completely done, particularly in the development of biographical data on Harrison physicians in practice from 1874 to 1977.

But it's the manner in which much of the material has been assembled and presented that's far more important. In brief, Mrs. Hess has recaptured and given new emphasis to something best described as values. And in this current topsy-turvy world, there's either too little time or too little inclination to pay much attention to these very basic components of life.

Let's take, for example, the career of Xenia Ethel Bond (1870-1940) and her long years of practice, beginning in 1905, in Salem. "Doctor Bond traveled the streets of Salem in the early 1900s by horse and buggy," Mrs. Hess has written. "Later, she bought a car but was too busy to learn to drive and only kept it for a brief time. For years she could be seen at any hour of the day or night walking to the bedside of a sick person or hurrying to deliver a baby.

"Her records show that she delivered more than 1,000 babies in home deliveries, and experienced no maternal deaths. Her fee for ob-

stetric care through most of her practice was $17, which included prenatal care, delivery and care of the mother and baby for 10 days. She would visit the home twice a day for the first few days to bathe the mother and baby and superintend the welfare of the two . . ."

A bit of history? A story of times that never will be repeated? An example of the kind of care that was offered many times over in about any part of the state you might mention? The answer to all these questions, of course, is "yes."

But the significant thing is that—while the times have changed and medical care is far, far more sophisticated—the same basic values exist today as in the early 1900s in Salem.

Medicine's great traditions, and its real strengths in relation to the American people in 1978, unfortunately are, however, things that the Califanos and Kennedys seem reluctant to recognize.

American medicine has been, and is, a great story. Mrs. Hess has done much to give that story new flavor and credibility.

RATIONING COMES TO WEST VIRGINIA

Dr. George Pickett, Director of the West Virginia Department of Health, made a speech a year or so ago as the outgoing President of the American Public Health Association in which he appeared to advocate a system of socialized medicine. The publication of this speech in the daily press caused quite a flap throughout the state. Many physicians were outraged that one with an ideology so foreign to the West Virginia temperament should be made the head of the State Health Department. *The Journal* made certain editorial comments shortly thereafter and then provided Doctor Pickett space via a special article to explain, excuse and defend himself.

Another speech by Doctor Pickett which deserves some comment has come to our attention. In an address to the West Virginia Hospital Association in October at White Sulphur Springs, Doctor Pickett, without using the term *rationing*, rather openly talks of the need for West Virginia to accept the concept of rationing. He notes that "just as Detroit has 'down-sized' its cars to conserve fuel it may be possible to 'down-service' a hospital to reduce cost ——."

We certainly have no objection to discussion of such matters by Doctor Pickett or by any member of the governmental bureaucracy. We regret that Doctor Pickett or anyone enamored of a centralized, controlled and regulated medical care system, in broaching such a delicate subject, finds it necessary to use such euphemisms.

We have a full appreciation of the problems they face and, quite frankly, try as we may, we can think of no other way than the one they choose to gull the public into accepting something it really wouldn't buy if it were presented in more precise and honest terms. Doctors understand this. Unpalatable medicine has always been disguised in some flavored vehicle.

Yet, it is really *rationing* that is being proposed and discussed by Doctor Pickett. That saccharine concoction of a "down-serviced" hospital is simply not adequate to disguise the bitter taste of rationing.

That nauseous term just regurgitated, George. You'll have to try again. Why not honesty? Let's talk about why it is necessary to ration medical care in West Virginia. If it is really good medicine, if it is life and death for medical care in West Virginia, the public will just have to hold its nose and take the big gulp.

We suspect, however, that this is just plain bad medicine. Dosing West Virginia with this nostrum is quite likely to lead to an iatrogenic malady which can rapidly produce a moribund condition.

Our Readers Speak

Carbohydrate Not To Blame

I was pleased to read your editorial titled "Eat to Live" until I got to one sentence. I beg for entry in your "letters" department!

> "This [affluent-culture heart disease, hypercholesterolemia and triglyceridemia] may relate to excess weight and high fat and carbohydrate intake."

And *carbohydrate* intake? And what, pray, contributes the majority of calories in cultures having no heart disease? Carbohydrate. Or to be more specific, complex carbohydrate. The vegetarians of the world are notably free of not only heart disease and hyperlipidemias, but also of diabetes mellitus and obesity—not we protein-lovers. Contrary to firmly held but wrongly held beliefs by almost all physicians, complex carbohydrate is *hypo*triglyceridemic for almost all individuals.

The protein RDA for a 70-kg man eating 2500 calories is 56 g or 225 calories. If we put him on a low-fat diet (say, 25 per cent), that takes another 625 calories. The remaining 1,650 calories should be from natural starches with fiber intact—or, the equivalent of 23 and one-half slices of whole-wheat bread per day!

Rebecca Riales, Ph. D.
Clinical Nutrition Consultant
600 Eighteenth Street
Parkersburg 26101

GENERAL NEWS

Vaccines,Chemotherapy-Hematology To Be Conference Subjects

Speakers on vaccines and chemotherapy-hematology have been announced by the Program Committee for the 12th Mid-Winter Clinical Conference to be held January 26-28 in Charleston at the Holiday Inn Charleston House.

Robert B. Belshe, M. D. Lee P. Van Voris, M. D.

Speaking Saturday morning, January 27, during the session on "Current Practices in Immunization" will be Dr. Robert B. Belshe, Associate Professor of Medicine and Chief, Section of Infectious Diseases, Marshall University School of Medicine, whose topic will be "Live Viral Vaccines," and Dr. Lee P. Van Voris, M. D., Assistant Professor of Medicine, MU, "Bacterial Vaccines."

David P. Lee, M. D., Charleston internist specializing in hematology and oncology, will speak during the concluding Sunday morning session entitled "Current Concepts in Hematology." His subject will be "Complications of Chemotherapy."

In addition to the sessions mentioned above, there will be an opening scientific session Friday afternoon, January 26, on "Physical Fitness, Obesity and Diet Therapy" and a Saturday afternoon session on "Coronary Artery Disease."

The annual continuing education event is sponsored by the State Medical Association and the West Virginia and Marshall University Schools of Medicine.

The conference schedule also will include, as announced previously, a Friday evening physicians' session, a Friday evening public session developed from the Friday afternoon physicians' session on "Physical Fitness, Obesity and Diet Therapy," and a cash bar and dinner program Saturday evening.

The conference is approved for 12 credit hours in Category 1 of the American Medical Association Physician's Recognition Award—and also is acceptable for 12 prescribed hours by the American Academy of Family Physicians.

University of Illinois Graduate

Doctor Belshe came to MU in 1976 after serving as a research associate with the U. S. Public Health Service in Bethesda, Maryland, in 1975-76. He is certified by the American Board of Internal Medicine, a member of the American Federation for Clinical Research, and an Associate Member of the American College of Physicians.

Born in Hartford, Connecticut, Doctor Belshe received his secondary education in Normal, Illinois, and was graduated from the College of William and Mary in Williamsburg, Virginia, where he was a member of Phi Beta Kappa. He received his M. D. degree in 1973 from the University of Illinois College of Medicine in Chicago, where he was a James Scholar and winner of the Student Research Forum. He served an internship and residency in medicine at the University of Illinois Hospital from 1973 to 1975.

Doctor Belshe, who also is a staff physician at Huntington Veterans Administration Hospital, is the author or co-author of 22 scientific articles and abstracts.

Comes From University of Rochester

Doctor Van Voris joined the Marshall faculty this year after serving as Instructor and Fellow in the Medicine/Infectious Disease Unit of the University of Rochester (New York) School of Medicine and Dentistry since 1976. In Huntington, he also is a staff physician at the Huntington Veterans Administration Hospital and associate attending physician at Cabell-Huntington and St. Mary's hospitals.

Certified by the American Board of Internal Medicine, Doctor Van Voris is an Associate Member of the American College of Physicians and a member of the American Society of Microbiology.

A native of Bethlehem, Pennsylvania, he was graduated from Kenyon College and received his M. D. degree in 1971 from the State University of New York Upstate Medical Center in Syracuse. He interned at Los Angeles Harbor General Hospital at Torrance, California, and served residencies in medicine there and at SUNY Upstate Medical Center.

Native of Nitro

Doctor Lee, a member of the Charleston Medical Group, is on the active staff of Charleston Area Medical Center, Department of Medicine, with practice limited to internal medicine and hematology/oncology. He also is Clinical Associate Professor of Medicine, West Virginia University School of Medicine.

Certified by the American Board of Internal Medicine, Doctor Lee is a member of the American College of Physicians and the American Society of Hematology.

A native of Nitro, he was graduated from WVU and received his M. D. degree in 1970 from the WVU School of Medicine. He interned at Memorial Hospital in Charleston, and completed a residency in internal medicine and a fellowship in hematology and oncology at the University Hospital of Jacksonville (Florida) in 1974.

Previously Announced Speakers

Previously announced speakers and their topics include:

Friday Afternoon: "Overuse Syndromes in the Recreational Athlete"—Fred L. Allman, Jr., M. D., The Sports Medicine Clinic, Atlanta; "Our Overgrown Children"—Ruth C. Harris, M. D., Professor and Chairman of Pediatrics, MU, and "Management of Cholesterol and Triglycerides"—Frederick J. Stare, M. D., Professor of Nutrition, Harvard University School of Public Health;

Friday Evening: "A Progress Report on Fee-for-Service HMOs"—Richard H. Egdahl, M. D., Director, Boston University Health Policy Institute;

Saturday Morning: "Influenza Virus Vaccines"—Ronica M. Kluge, M. D., Associate Professor of Medicine and Chairman, Division of Infectious Diseases, WVU, Morgantown;

Saturday Afternoon: "Coronary Artery Medicine and Surgery: Concept and Controversy"—John C. Norman, M. D., Cardiovascular Surgeon, Texas Heart Institute, Houston, and

Sunday Morning: "The Anemia of Cancer"—Peter C. Raich, M. D., Professor of Medicine and Chairman, Division of Hematology-Oncology, WVU, Morgantown, and "Current Use of Blood Products"—Mabel M. Stevenson, M. D., Medical Director, Tri-State Red Cross Blood Center, Huntington.

Other Program Information

A registration fee of $25 for the entire conference, including the Saturday evening dinner, will be charged to all registrants except nurses, medical students, interns and residents.

All extra tickets (not included in the registration fee) for the dinner session Saturday must be purchased by 10 A. M. on that day. Such tickets ($7.50 each) would include those for spouses and other guests—and for nurses, medical students, interns and residents.

These tickets will be available at the registration desk beginning with registration Friday afternoon.

All other registrants paying the $25 fee will receive their dinner tickets when they register at the conference.

Remaining speakers and final details of the conference program will appear in the January issue of *The Journal*.

Cabell Auxiliary Spearheads Health Education Effort

Dr. Robert D. Hess' "President's Page" in the October issue of *The Journal*, calling for more emphasis on health education and nutrition in primary and secondary schools, struck a responsive chord with members of the Auxiliary to the Cabell County Medical Society.

The following is a letter directed to Doctor Hess and *The Journal* by Mrs. C. E. Turner of Huntington, and its content was deemed worthy of general distribution to *Journal* readers.

"I read with interest your message in the *Medical Journal*," Mrs. Turner wrote, and then continued: "Your goals are commendable and I especially took note of your paragraph dealing with a needed emphasis on health education in primary and secondary schools.

"I'm not sure if you are familiar with what the Auxiliary in Cabell has been able to do, but the enclosed photo and brief article will give you a

thumbnail sketch (Mrs. Turner provided a newspaper clipping about the Auxiliary's donation to the Cabell Board of Education of $3,694.33 to cover the cost of models of the human torso to be used for educational purposes. Each model packet contains detail of the inner organs, an eye, an ear and teaching tapes).

"Nearly four years ago, we began with a 'Health is Happiness Fair'—an 'in-person' look, and 'see and touch' exploration and explanation of the body systems' functions and care. This grew into an educational television series, "See You," through WMUL in Huntington. One of our members, Marianne (Mrs. Harry) Tweel wrote 10 fifteen-minute scripts and I did the TV teaching. This is now available on the educational stations here, in Beckley and in Morgantown.

"In addition, some 30 stations on the East Coast have purchased this for use in the classroom. Marianne and I donated our salaries—our Auxiliary matched that money as did the Board of Education, and in turn federal funding was received. This brought about the possibility of purchasing the items mentioned in the article . . .

"In the near future, our members will be offering in-service teaching to classroom teachers in the use of the materials and models. In other words, we are all thrilled with the possibilities. All schools with educational hook-ups can receive these lessons on television. Perhaps other county boards would welcome 'seed money' from auxiliaries to match for teaching aids. This entire project has been written up for our Auxiliary's national magazine, *Facets*, (for use in) the winter issue forthcoming. Would the men's *Journal* carry information?

"Betsy Ratcliff (Mrs. Gilbert, Jr.) tells me that her husband's state pediatrics chapter has some of the same goals as you in the coming year. Material is available on how they hope to accomplish this. If you need information on this or more about how our county started and carried out this boost to Cabell's health education program, please feel free to contact me. Betsy is our local Auxiliary Health Education Chairman (533 10th Avenue, Huntington 25701, telephone 529-3552).

"Marianne Tweel's address is 86 Camelot Drive, telephone 697-2294. I can be reached at 525-6526 (Mrs. Turner's address is 211 Whitaker Boulevard West, Huntington 25701)."

Mrs. Turner and her husband, a Huntington internist, wished Doctor Hess "well in this coming year."

Continuing Education Activities

Here are the continuing medical education activities listed primarily by the West Virginia University School of Medicine for part of 1978 and 1979, as compiled by Dr. Robert L. Smith, Assistant Dean for Continuing Education. The schedule is presented as a convenience for physicians in planning their continuing education program. (Other national, state and district medical meetings are listed in the *Medical Meetings* Department of The Journal.)

The program is tentative and subject to change. It should be noted that weekly conferences also are held on the Charleston and Wheeling campuses as well as in Morgantown. Further information about these may be obtained from: Division of Continuing Education, WVU Medical Center, 3110 MacCorkle Avenue, S.E., Charleston 25304; Office of Continuing Medical Education, WVU Medical Center, Morgantown 26506; or, Office of Continuing Medical Education, Wheeling Division, WVU School of Medicine, Ohio Valley Medical Center, 2000 Eoff Street, Wheeling 26003.

Dec. 6	Morgantown	Infant Nutrition
Mar. 23	Charleston	Sixth Annual Newborn Day
April 6, 7	Morgantown	Internal Medicine Days
April 6, 7	Morgantown	Cancer Teaching Days
April 15	Wheeling	Pediatrics Seminar
May 10, 11	Morgantown	Health Officers Seminar
May 19	Wheeling	Seminar on Surgical Problems

ACC Fellow

Dr. John D. Harrah of Huntington has been named a Fellow of the American College of Cardiology (ACC). The announcement was made by Dr. A. C. Jain of Morgantown, ACC Governor for West Virginia.

Two Association Scholarship Replacements Announced

Two new recipients of 1978 State Medical Association scholarships have been named in the place of previously announced recipients who have surrendered their Association scholarships and accepted other scholarships.

James D. Clay

Marvin L. Sponaugle III

The two new recipients are James D. Clay of Belle (Kanawha County), who had been designated First Alternate by the Association's Committee on Medical Scholarships, and Marvin L. Sponaugle III of Franklin (Pendleton County), Second Alternate.

Clay replaces Rosanna Sikora of Weirton, and Sponaugle replaces Veda Lynn Ackerman of Wheeling. All are first-year students at West Virginia University School of Medicine.

Both of the new recipients will receive grants of $1,250 for each of their four years at WVU.

Clay, son of Mrs. Nancy Clay of Belle and the late Mr. Clay, has an undergraduate degree in chemistry from Alderson-Broaddus College.

Sponaugle received a B. A. degree in chemistry from WVU last May. He is the son of Mr. and Mrs. Marvin L. Sponaugle, Jr., of Franklin.

Under provisions of their scholarship agreement, recipients must agree to practice in West Virginia for four years following graduation and completion of any postgraduate training and/or military obligations.

The original four 1978 scholarship winners were announced in August by Dr. John Mark Moore of Wheeling, Chairman of the Medical Scholarships Committee. The committee conducted interviews of applicants from this fall's first-year class at WVU and Marshall University School of Medicine June 10-11 in Parkersburg.

The other two scholarship recipients are Anthony Lee Burke of Charleston, WVU student, and Darrell William Jordan of Ona (Cabell County), the first MU School of Medicine enrollee to receive a Medical Association scholarship.

WVU Anesthesiology Visiting Professor Schedule

Below is the 1979 Visiting Professor Series for the Department of Anesthesiology at the West Virginia University Medical Center in Morgantown. The Visiting Professor conferences are held at 4 P. M. on Thursdays and 7:15 A. M. on Fridays on the dates indicated:

"Mechanism of Action and Toxicity of Local Anesthetics"—Cosmo DiFazio, M. D., Professor of Anesthesiology, University of Virginia Medical Center, February 8 and 9; "Current Concepts of Anesthetic Action"—Edward Brunner, M. D., Chairman, Department of Anesthesiology, Northwestern University Medical School, Chicago; March 15 and 16;

"The Pharmacology of Anti-Cholinesterase Action"—Richard J. Kitz, M. D., Anesthetist-in-Chief, Massachusetts General Hospital, Harvard Medical School, Boston, April 26 and 27, and "Anesthesia for Cardio-Vascular Surgery in Children"—David J. Stewart, M. B., Anesthetist-in-Chief, The Hospital for Sick Children, Toronto, June 8.

The Annual Meeting of the West Virginia State Society of Anesthesiologists will be held on June 9 at the Medical Center, at which time Doctor Stewart will speak on "Pediatric Outpatient Anesthesia."

The Visiting Professor conferences meet the criteria for one hour of credit in Category 1 of the Physician's Recognition Award of the American Medical Association—and also are approved for 0.1 WVU CEUs.

Other speakers and topics for the Annual Meeting will include "Halothane and the Liver —Over 15 Years of Controversy"—William Forrest, Jr., M. D., Stanford University School of Medicine, Palo Alto, California; "V/Q Abnormalities are the Commonest Cause of Hypoxia in Medicine"—Azmy R. Boutros, M. D., Chairman, Division of Anesthesiology, Cleveland Clinic, and "Low Cardiac Output States: Pathophysiology and Management"—Demetrios Lappas, M. D., Department of Anesthesia, Massachusetts General Hospital, Boston.

Review A Book

The following books have been received by the Headquarters Office of the State Medical Association. Medical readers interested in reviewing any of these volumes should address their requests to Editor, *The West Virginia Medical Journal*, Post Office Box 1031, Charleston 25324. We shall be happy to send the books to you, and you may keep them for your personal libraries after submitting to *The Journal* a review for publication.

Current Obstetric & Gynecologic Diagnosis and Treatment, 2nd Edition, by Ralph C. Benson, M.D. 976 pages. Price $18. Lange Medical Publications, Los Altos, California 94022. 1978.

The Metabolic Management of the Critically Ill, by Douglas W. Wilmore, M. D. 262 pages. Price $22.50. Plenum Publishing Company, New York, New York 10011. 1977.

Talk Back to Your Doctor, by Arthur Levin, M. D. 245 pages. Price $7.95. Doubleday & Company, Inc., 245 Park Avenue, New York, New York 10017. 1975.

Review of Medical Microbiology, 13th Edition, by Ernest Jawetz, Ph. D., M. D.; Joseph L. Melnick, Ph. D., and Edward A. Adelberg, Ph. D. 550 pages. Price $12. Lange Medical Publications, Los Altos, California 94022. 1978.

Sammons Praises Chamber's Cost Containment Program

"This is a sensible approach to cost containment," James H. Sammons, M. D., American Medical Association Executive Vice President, said about the program announced in November by the United States Chamber of Commerce. The Chamber's National Health Care Strategy campaign will show business and industry how to take action to curb their costs and improve the system. The program is based on a study conducted for the National Chamber Foundation by InterStudy, a Minneapolis health care consulting firm. InterStudy produced a series of reports with specific action programs aimed at controlling costs, stimulating competition in the system, promoting good health for employees, and improving health planning and regulation.

"The program centers on the private sector, on people who know how to get things done," Doctor Sammons commented. "The subjects covered in these reports are the very ones that AMA officials have been discussing in visits with corporate leaders since last June. We have talked with the top management of about 30 firms, and we have found them to be concerned and eager to involve themselves."

In 1977, according to the study, business spent more than $34 billion on employee health insurance programs and a comparable amount on workers' compensation, disability programs, sick leave, and tax-supported state and federal health programs. At a press conference, Chamber President Richard Lesher said massive government programs to solve health care cost problems "would only compound our problems and further fuel inflation at a time when most Americans are saying, 'Enough!' to government growth." Paul M. Ellwood, Jr., M. D., President of InterStudy, said the reports show business how it "can use its clout to help improve the performance of the health system."

The study calls for business executives to establish health care policies for their firms, evaluate their community health care system, seek immediate savings by changing the design of their benefit programs when necessary, promote alternative delivery systems by offering them as options and helping to organize them, direct a portion of their health care dollars to prevention programs, and participate in health planning in both the public and private sectors.

Members of the Chamber's Special Committee on the Nation's Health Care Needs will serve as a task force to help companies and communities implement the program. Guidance for the National Chamber Foundation project was provided by a steering committee composed of individuals from the business, insurance and health care fields. AMA Deputy Executive Vice President Joe D. Miller is a member of both the task force and the steering committee.

Re-Structuring Of JCAH Voted By Board

A re-structuring of the Joint Commission on Accreditation of Hospitals was voted last month by its Board of Commissioners. The action will result in dissolution of the four accreditation councils, broadening of national professional support, and strengthening of the organizational structure under President John E. Affeldt, M. D. The JCAH Board had reviewed a number of studies showing the need for a management structure that would reduce the confusion of staff roles and reporting relationships.

The action also calls for the establishment of a Policy Advisory Committee to the Board, the establishment within JCAH of Professional and Technical Advisory Committees to each accreditation program, the transfer of all accreditation programs into a Division on Accreditation, and the development of a department on multicategory surveys within that division, the establishment of a Division of Education and Publishing, and the establishment of a Department of Corporate Planning.

Written agreements will be terminated by June 30, 1979, with 24 national organizations represented on the accreditation councils for facilities serving mentally retarded-developmentally disabled persons, long-term care facilities, psychiatric facilities, and ambulatory health care. The Professional and Technical Advisory Committee for each of these programs—as well as the PTAC for the hospital accreditation program, which was not directed by a council—will be composed of relevant national organizations and recognized specialists.

Doctor Affeldt said the formation of these PTACs and of a Policy Advisory Committee assures and broadens the continued influence of major national organizations in voluntary accreditation. The 30-member PAC will advise the Board on generic policies and on national and professional issues affecting accreditation. The JCAH Board is made up of appointees from the AMA, American College of Physicians, American College of Surgeons, and American Hospital Association.

Scientist Raises Mice Embryos Outside The Womb

A scientist in Baltimore has successfully raised embryo mice in the laboratory until they are halfway through gestation and their heart cells begin beating.

According to a recent Washington Post article, Dr. Yu-Chih Hsu isn't sure a mouse or any other mammal, including a human, can be brought completely to "birth" or maturity outside the womb. "It might never be done. Or it might be done in the mouse by someone in a very short time."

Doctor Hsu works at the Johns Hopkins School of Hygiene and Public Health. He hopes one day that science may be able to use trays of mouse embryos as a valuable and sensitive test system to learn whether new drugs or chemicals cause birth defects or cancers.

Medical Meetings

Dec. 1-4—Cystic Fibrosis Foundation, Atlanta.

Dec. 2-6—AMA Delegates Winter Meeting, Chicago.

Dec. 2-7—Am. Academy of Dermatology.

Dec. 7-10—AMA Winter Scientific Session, Las Vegas.

Dec. 8—Med. Rehabilitation Conference, Charleston.

1979

Jan. 4—Dept. of Pediatrics, CAMC (Guest Lecture Series), Charleston.

Jan. 15-16—International Glaucoma Congress, Las Vegas.

Jan. 15-16—International Congress of Cardiovascular Disease & Surgery, Las Vegas.

Jan. 15-18—Dept. of Anatomy, MCV (Alton D. Brashear PG Course in Head & Neck Anatomy), Richmond.

Jan. 26-28—12th Mid-Winter Clinical Conference, Charleston.

Jan. 27-31—Am. College of Allergists, San Francisco.

Feb. 23-24—Va. Chap., Am. Academy of Pediatrics, Williamsburg.

Feb. 23-27—Biofeedback Society of Am., San Diego.

March 1—Dept. of Pediatrics, CAMC (Guest Lecture Series), Charleston.

March 7-9—Nurses Assn. of Am. College of Obstetricians & Gynecologists, Chicago.

March 11-15—Am. College of Cardiol., Miami Beach.

March 22-29—Am. Society of Clinical Pathologists, New Orleans.

March 24-28—Am. Academy of Allergy, New Orleans.

March 30-April 1—W. Va. Chap., AAFP, Charleston.

March 31-April 1—Am. Otology Society, Los Angeles.

April 2-5—ACS, Denver.

April 3-4—Am. Broncho-Esophagological Assn., Los Angeles.

April 22-25—W. Va. Academy of Ophthalmol. & Otolaryngol., White Sulphur Springs.

April 23-28—Am. Academy of Neurology, Chicago.

April 26-29—ASIM, New Orleans.

May 24—Dept. of Pediatrics, CAMC (Guest Lecture Series), Charleston.

July 21-26—AMA Delegates Summer Meeting, Chicago.

Aug. 22-25—112th Annual Meeting, W. Va. State Medical Assn., White Sulphur Springs.

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WVU Medical Center
—News—

Compiled from material furnished by Mrs. Mary Ellin Wylie, Director, Medical Center News and Information Services, Morgantown, W. Va.

Physician Practices 10 Years In Israel Hospital

"If Christianity is to have meaning, it must be lived in a practical way."

That's the way Dr. Robert W. Martin, WVU Health Service physician, summarizes the philosophy which led him to spend 10 years practicing medicine in a 120-bed Christian hospital in Israel. His patients were drawn primarily from the 40,000 Arab population of Nazareth and from the surrounding villages of lower Galilee.

The York, Pennsylvania, native, a graduate of Eastern Mennonite College and Hahnemann Medical College, first went to Israel in 1965 after completing his internship at Harrisburg, Pennsylvania General Hospital. He was accompanied by his wife and their 14-month-old son, Craig.

His two-year assignment, which was to stretch into 32 months, was made through the Mennonite Board of Missions and was in lieu of military service.

While in Israel, Doctor Martin and his wife received instruction in Arabic, the language in which he conducted his practice. Mrs. Martin, a nurse, taught part-time in the hospital's school of practical nursing.

Nazareth Hospital in Galilee was founded in 1864 by the Edinburgh Medical Missionary Society during the Turkish rule of Palestine and was at that time the only hospital between Jerusalem and Beirut.

It was established in response to the medical and spiritual needs in Palestine and later expanded its function to serve in training doctors for medical mission work, particularly in Africa and Asia.

"The hospital fulfilled a great need and has continued today as a Christian witness and service to the people of Nazareth and surrounding villages," Doctor Martin said. "Until 1967, it was the only Protestant hospital in Israel."

When the Martins left Israel in 1968 with their two children (daughter Karen had been born the previous year), they had no intention of returning.

"It had been a good experience," Doctor Martin explained. "We thought, 'Well that was it.' But when the head of medicine at the hospital returned to England when I was half-way through my medical residency at George Washington University and I was offered the job upon completion of it in 1971, we decided to go back."

Thomas R. Adamski of Elkins (right), first-year student at WVU School of Medicine, talks in the Medical Center library with Kenneth R. Sears, WVU financial aids officer. Adamski and another Randolph Countian, Charleston-based, third-year WVU medical student Joan Antolini Phillips of Norton, are this year's recipients of B. I. Golden Scholarships given by Memorial General Hospital in Elkins in honor of retired and deceased staff members. This is the fourth year the scholarships have been awarded, and the first year two have been given. The school's student welfare committee makes the selections from among deserving medical students from one of these counties: Randolph, Tucker, Pocahontas, Webster, Upshur, Barbour and Pendleton.

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Third-Party News, Views and Program Concerns

Preventive Care Large Factor In Child Health Status

Preliminary findings from a study on determinants of children's health indicate that family income apparently has little impact on the health status of white children 6 to 11 years of age. This finding suggests that income transfer policies directed toward improving children's health will have little or no effect on children beyond their first year.

A study by the National Bureau of Economic Research, New York City, finds that the level of the parents' education and the use of preventive health services are, however, strong determinants of children's health. Dr. Michael Grossman also found that the presence in the home of women who are either spouses or heads of households made little difference to the health of their children. In addition, there appeared to be no difference in the health of black and white children of similar family characteristics and, according to some health measures, the black children appeared in better health.

In an analysis of possible nutritional reasons for differences in health, the investigators found that the diets of low-income children of up to 3 years of age proved adequate or better as measured by caloric and protein intake. The study, to be completed in 1979, is expected to provide important information for further investigation of the mechanisms which link home environmental characteristics to children's health.

Practice Evaluation Committee Named By AMA Board

An Ad Hoc Committee on Practice Evaluation has been named by the Board of Trustees of the American Medical Association to review Recommendations 25 and 30 of the National Commission on the Cost of Medical Care. The committee, which was authorized by the House of Delegates at the 1978 Annual Convention, is scheduled to report to the Board in March. Recommendation 25 deals with the development of guidelines by PSROs and other reviewing boards. Recommendation 30 calls for guidelines to be used by providers and the courts in determining appropriate care.

Appointed to the committee are Burns A. Dobbins, Jr., M. D., Fort Lauderdale, Florida, Chairman of the Judicial Council; C. John Tupper, M. D., Davis, California, Chairman of the Council on Scientific Affairs; James B. Snow, Jr., M. D., Philadelphia, Council on Scientific Affairs; Robert T. Kelly, M. D., Grand Rapids, Minnesota, Chairman of the Council on Medical Service, and John Glasson, M. D., Durham, North Carolina, Vice-Chairman of the Council on Medical Service.

Risks Of Progestin In Pregnancy Outlined In Brochure

The Food and Drug Administration recently took action to warn women about the risks of using the female hormone progestin during the early stages of pregnancy.

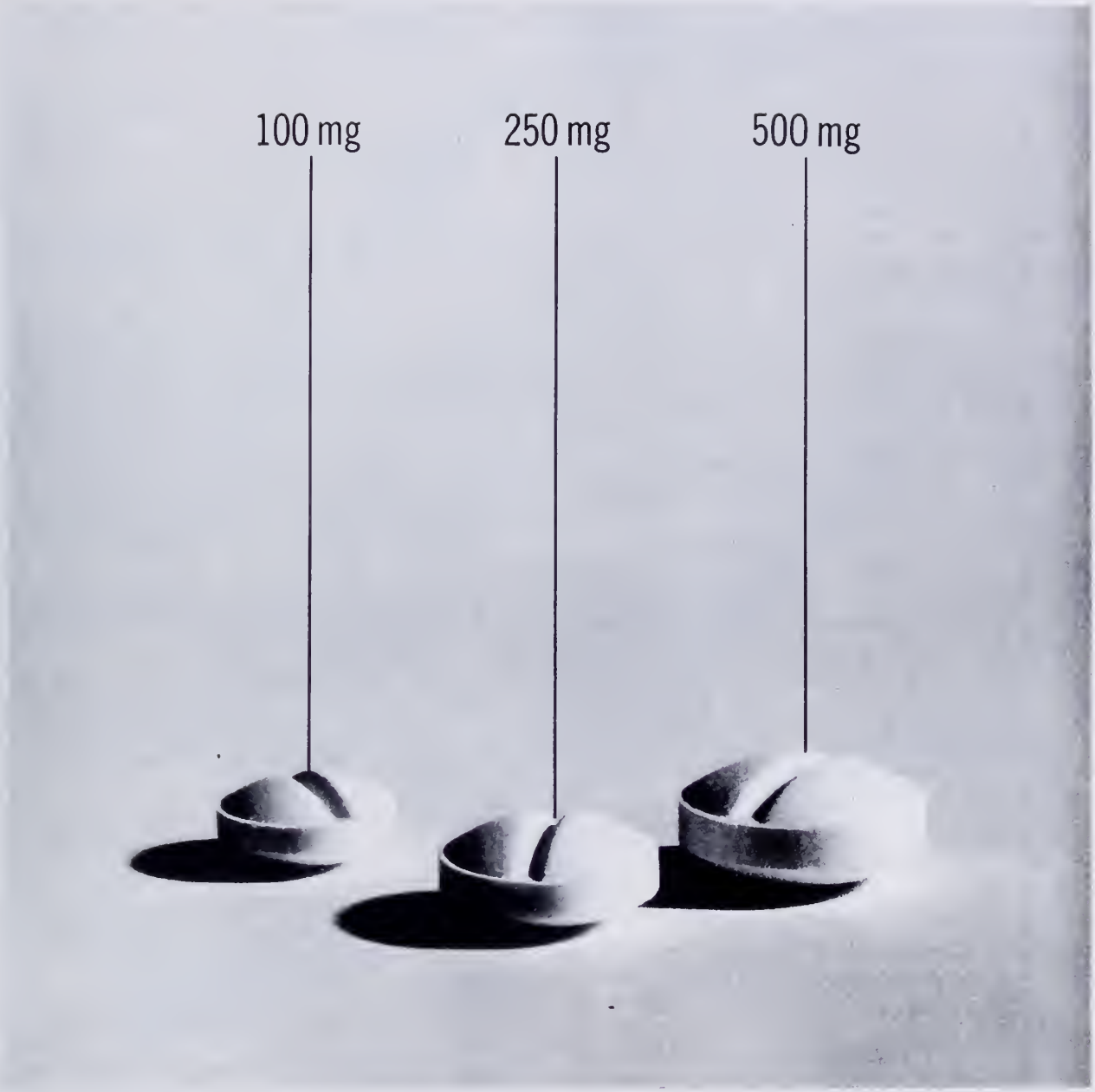
Starting December 11, a lay-language brochure on progestins must be given to women by the dispensing physician or pharmacist whenever a prescription is filled.

The brochure will point out that progestins, when taken by women in the first four months of pregnancy, may increase the risk of heart defects or deformed arms and legs in their children.

Progestin prescription drugs are used by women with menstrual disorders or abnormal bleeding of the uterus.

The drugs once were used for pregnancy tests but the FDA no longer considers them safe for this purpose. The patient brochure will point this out.

The most common brand names of prescription drugs containing progestins are Delalutin, Duphaston, Norlutate, Norlutin, and Provera.



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Obituaries

THOMAS M. HOWES, M. D.

Dr. Thomas M. Howes, Morgantown family physician for more than 14 years, died on October 27 in a hospital there after a long illness. He was 43.

Doctor Howes began practice in Morgantown in July, 1961, but left the following January to serve in the U. S. Air Force Medical Corps. He was stationed in Charleston, South Carolina, with the rank of Captain.

Doctor Howes returned to Morgantown in May, 1964, and maintained an office for family practice until ill health forced him to retire some months ago. He also had served as Associate Professor of Physical Diagnosis at the West Virginia Medical Center in Morgantown.

Born in Marlinton, he was graduated from Charleston High School and WVU, receiving his M. D. degree in 1960 from the Medical College of Virginia. He interned at Charleston Memorial Hospital.

Doctor Howes was a member of the Monongalia County Medical Society, the West Virginia State Medical Association, the American Medical Association, and the West Virginia Chapter, American Academy of Family Physicians.

Survivors include the widow; four daughters, Mrs. Charles Stalnaker of Morgantown, and Susan Lynn, Ann Margaret and Andrea Howes, all at home; two sons, Thomas M. and Anthony B. Howes, both at home, and the mother, Mrs. Margaret Kramer Howes of Charleston.

* * *

ARTHUR K. LAMPTON, M. D.

Dr. Arthur K. Lampton of Charleston died on November 1 in a hospital there. He was 62.

Doctor Lampton was a family physician, with an office in East Bank, near Charleston.

A native of Big Clifty, Kentucky, Doctor Lampton was graduated from the University of Louisville and received his M. D. degree in 1941 from that institution's School of Medicine. He served an internship and residency at Louisville General Hospital.

Doctor Lampton also held an M. S. degree in Pathology from the University of Louisville. He was a member of the Kanawha Medical Society, the West Virginia State Medical Association, American Medical Association, and Southern Medical Association.

Survivors include the widow; a daughter, Ms. Judith Lampton of Charleston, and three sisters, Mrs. Alice Kouns and Mrs. Wilma Smith, both of Louisville, and Mrs. Mabel Collins of Florida.

* * *

FREDERICK R. WHITTLESEY, M. D.

Dr. Frederick R. Whittlesey, retired internist and former faculty member of the West Virginia University School of Medicine in Morgantown, died there on November 3. He was 77.

A former member of the State Medical Association's Council, Doctor Whittlesey served as Assistant Dean of the University of Nebraska Medical School before going to Morgantown in 1930 to serve with the WVU Health Service, of which he was a former Director, and to teach in the then two-year School of Medicine.

He held the post of Emeritus Professor of Medicine at the Medical School at his retirement from practice in 1974.

Doctor Whittlesey gave the graduation address to the first class graduating from the new four-year School of Medicine in 1962.

A Fellow of the American College of Physicians, he was an honorary member of the Monongalia County Medical Society, the West Virginia State Medical Association and the American Medical Association.

Doctor Whittlesey was born in Shanghai, China, of American missionary parents, and received his early education in that country. He was graduated from the College of Wooster (Ohio) and received his M. D. degree in 1925 from Case Western Reserve University School of Medicine.

Survivors include two daughters, Mrs. J. Hugh Wiley of Morgantown and Mrs. Clare Whittlesey Weigel of Mill Hall, Pennsylvania; one sister, Mrs. James Spencer of New Wilmington, Pennsylvania, and two brothers, Al Whittlesey of Londonderry, Vermont, and Bob Whittlesey of South Yarmouth, Massachusetts.

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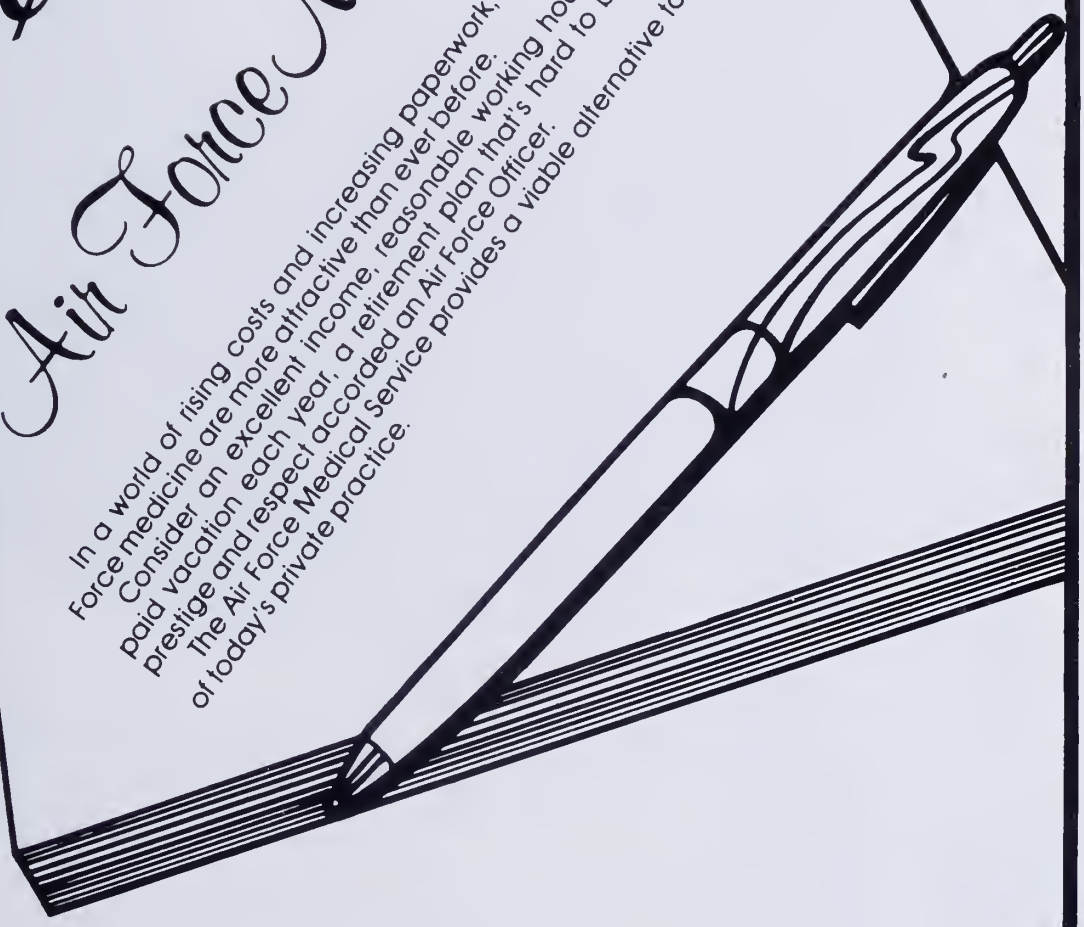

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County Societies

CABELL

The Cabell County Medical Society met on October 12 at the Gateway Inn in Barboursville.

The guest speaker, Dr. John A. Hunt, Associate Professor of Surgery at Marshall University School of Medicine, discussed carcinoma of the esophagus and other surgical problems.

Dr. James A. Heckman gave a review of the recent malpractice insurance changes that have occurred.

It was announced that the Cabell County Heart Association has a home nutritionist available for evaluation and follow-up with dietary programs at home for patients.—William J. Echols, M. D., President.

* * *

McDOWELL

The McDowell County Medical Society met on October 11 at the home of Dr. Bernard M. Swope of Welch.

Dr. Robert D. Hess of Clarksburg, President of the West Virginia State Medical Association, was the Society's honor guest and speaker. Doctor Hess spoke on the State Medical Association and its active role in quality health care for the population of the state, and then answered questions.—Muthusami Kuppusami, M. D., Secretary.

* * *

MERCER

The Mercer County Medical Society met on October 16 at Frankie's La Salute Club in Princeton.

The guest speaker was Dr. Herbert H. Peter of Duke University who gave an informative discussion on coronary arteriography and its significance in diagnosis and prognosis, as well as important areas in stress testing of normal and coronary patients.—David F. Bell, Jr., M. D., Secretary.

* * *

MONONGALIA

The Monongalia County Medical Society met on October 3 at the Old Mill Club in Morgantown.

The scientific program was presented by Dr. Donald C. Carter, Professor of Behavioral Medicine and Psychiatry at West Virginia University School of Medicine, whose topic was "Changes in the Legal Commitment Procedure in West Virginia."

The Society voted to make a donation (of $10 per medical student from Monongalia County) to the Student American Medical Association.—H. Summers Harrison, M. D., President.

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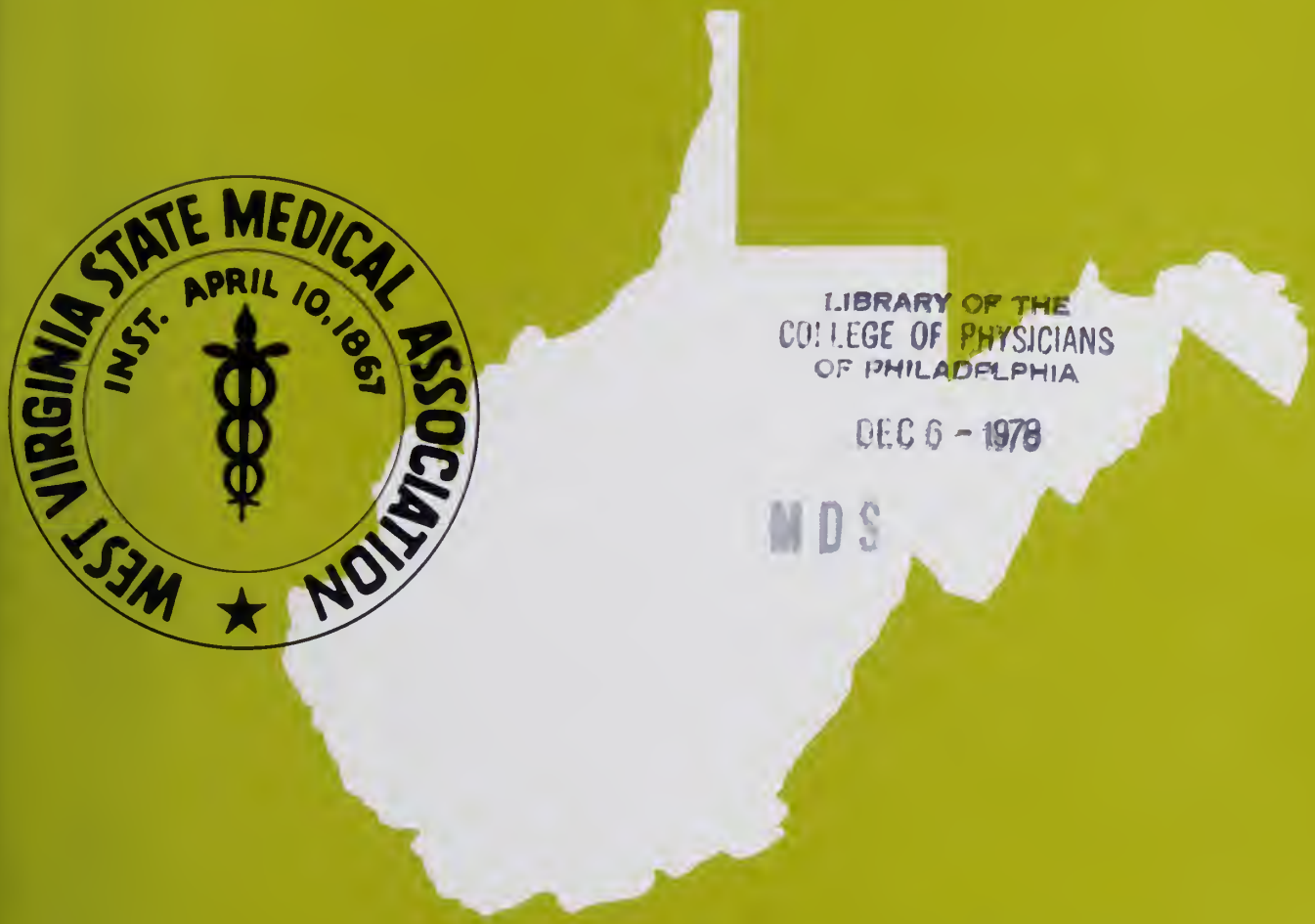

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